

THE ROYAL COLLEGE OF RADIOLOGISTS
CLINICAL RADIOLOGY PILOT OF PORTFOLIO APPROACH TO
RE-CERTIFICATION - REPORT

January 2009

A. Introduction

This report outlines the methodology and results of The Royal College of Radiologists (RCR) pilot study on the portfolio approach to recertification. The pilot was carried out by 31 volunteer Clinical Radiologists. The report ends with the conclusions and recommendations drawn from the pilot.

B. Background to Revalidation, Relicensing and Recertification

The White Paper, *Trust, Assurance and Safety – The regulation of health professionals in the 21st century* (1) was published by the Department of Health in February 2007. This document outlined proposals to introduce a system of revalidation for medical professionals. Revalidation is the process whereby doctors are required to demonstrate, on a regular basis, that they are up to date and fit to practise medicine.

Trust, Assurance and Safety divides revalidation into two components – relicensing and specialist recertification:

- Relicensing will be based on agreed generic standards of practice set by the GMC, a revised system of NHS appraisal for doctors and certification of suitability for relicensing by the relevant medical director. It will apply to all licensed doctors.
- Recertification will apply only to doctors who are on the specialist or GP registers. They will need to demonstrate that they continue to meet the standards that apply to their specialty.

C. RCR's Approach to Recertification

The RCR established a Recertification Committee in May 2007. Its remit was to serve as an overarching group for both the College's Faculties (of Clinical Oncology and Clinical Radiology) in order to define and implement the College's recertification policy.

The Committee started by defining the RCR's aims and objectives for recertification. These were put out to consultation with Fellows and members in the summer of 2007 and can be found at the following link:

<http://www.rcr.ac.uk/docs/general/pdf/FinalAimsandObjectives-Sept07.pdf>

The RCR wished to create a framework to help its Fellows and members to produce and collate the necessary evidence which would enable them to achieve

recertification. It would be important that the methods developed were fit for purpose but also flexible, transferable and realistic.

A portfolio approach was felt to be the most practical way of accomplishing this. This approach was put forward in the RCR's consultation on plans for recertification in the autumn of 2007 and feedback was supportive.

D. Background to and Aim of the Pilot

At the beginning of 2008, the RCR Recertification Committee believed that, although much of the final shape of revalidation, relicensing and recertification was still unclear, it was important to test the feasibility of the proposed portfolio approach. It was agreed that the best way of doing this would be to undertake a recertification portfolio pilot study through the Faculty of Clinical Radiology.

The pilot was not intended as a statistical analysis of the evidence or tools used or as an actual assessment of the performance of the volunteers. The aim of the pilot was purely to test the feasibility of the portfolio approach to recertification.

E. Method

Clinical radiologists were sought via the College's e-bulletin *Monthly News* to volunteer to submit a fully anonymised portfolio, consisting of four categories of evidence.

The categories were:

1. Multisource feedback (MSF) with both generic and specialty specific questions
The MSF category required the participant to have undertaken a MSF (360 degree appraisal) within the past five years and to submit the anonymised return. For those who had not undertaken MSF locally, the College commissioned the company 360 Clinical to run the MSF for the participant. A patient questionnaire was not included at this stage, although it was acknowledged that this would be necessary for full roll out. (N.B The College's Patients' Liaison Groups are carrying out a project to develop patient specific MSF questions).
2. Details of attendance at discrepancy / morbidity and mortality / appropriate audit meetings
Participants were asked to indicate if they regularly attended a discrepancy meeting and provide evidence of attendance eg attendance register etc. If they did not attend them, they were asked to give the reason why eg because they do not exist, pressure of work etc, and to provide or suggest an alternative piece of evidence to show their reflection on errors.
3. Evidence relevant to an individual's performance in practice
Participants were asked to submit one piece of evidence relating to their performance in practice. The necessary evidence for this category was the

most difficult to define as there is great variation in individuals' type and scope of practice. Suggested examples given were:

- Evidence of peer review of reported cases.
- Performance data.
- Individual audit data.
- Outcome/compliance data.

4. Continuing Professional Development (CPD)

Participants were asked to submit an anonymised photocopy of their CPD certificate showing they had completed a five year CPD cycle.

The principle behind the portfolio of evidence is that, with all the elements taken together, it should allow individuals to demonstrate that they are practising to a satisfactory level, in a way that is fair and equitable across and within specialties, whilst also encouraging further improvement in practice.

The four categories aim to address the following criteria:

- How the doctor is performing as judged by peers/patients
- Whether the doctor works within and contributes to an environment of learning from error
- Whether the doctor can provide evidence of their individual performance
- Whether the doctor keeps up to date with the rapid developments in medicine.

Participants were also asked to provide the date of their last appraisal and to complete an evaluation questionnaire on the process. They were asked to anonymise all documents before submission and all evidence was destroyed at the end of the project.

The assessment of the submitted portfolios was undertaken by the RCR for the purposes of the pilot, although the College would envisage the assessment process being undertaken locally when recertification is rolled out.

F. Timescales

The timescales for the project were:

January – February 2008	Discussions and decision making on content of portfolio. Scoping of pilot project.
March 2008	Discussions with MSF company.
April – July 2008	Production of generic and specialty specific MSF questions and on-line system. Recruitment of volunteers to participate in pilot. Creation of participant information pack.
August – November 2008	Pilot rollout.
1 December 2008	Deadline for receipt of anonymised pilot submissions.

Mid-December 2008	Assessment of submissions. Analysis of pilot and feasibility of portfolio approach.
January 2009	Production of pilot report.

G. Outcome

In total, 31 completed and anonymised submissions were received from clinical radiologists. Of these, 26 also completed the pilot evaluation questionnaire.

A panel consisting of the RCR Recertification Lead, the Registrar of the Faculty of Clinical Radiology, the Chair of the RCR's Clinical Radiology Patients' Liaison Group and an elected member of the Clinical Radiology Faculty Board met to look at the portfolios, and to assess whether they would represent a feasible approach to recertification.

A separate analysis of the evaluation questionnaires was also undertaken.

H. Results

The results of the pilot will be considered in two sections:

1. the findings of the assessment of the submitted portfolios
2. the results of the analysis of the evaluation questionnaires.

1. Assessment of the Portfolios

As detailed above, a small group (which included a lay representative) met to assess the submitted portfolios. The group's objective was to consider the portfolios and decide whether the portfolio approach would represent a feasible way of achieving recertification.

To this end, the portfolios were assessed under the following criteria:

- Whether there was sufficient evidence.
- What was missing.
- Whether the individual had proved his/her fitness to practise.
- Other observations.

General findings

The group's general findings on the portfolios were:

- The group identified no fitness to practise issues in the pilot submissions.
- Some participants would readily have achieved recertification with the portfolios they submitted in that they had provided sufficient evidence to demonstrate their fitness to practice.
- It was apparent from the nature of the evidence provided that this would in some cases be considered insufficient evidence. For example, pilot participants were required to supply only one piece of data in section 3,

'evidence of performance'. From the data received it was evident that much more specific guidance would be needed for this section.

- It was generally easier for breast and interventional radiologists to provide evidence than other sub-specialties. This is due either to the nature of the specialty lending itself more easily to outcome data (interventional) or to tools already being in existence which are able to be used for assessing performance in a nationally structured case file, which is used by all breast screening radiologists
- Guidance and much clearer examples of the types and amount of evidence to be submitted would be needed. This was particularly apparent in the third category (evidence of individual performance in practice).
- To ensure that the evidence submitted covered the breadth of the individual's practice, it would have been useful to have also asked for a statement of usual work pattern/range of practice. This would be particularly important if the College has any role in quality assuring portfolios. It may not be so applicable to portfolios assessed at the local level where usual areas of practice should be known.
- Doctors would need reasonable notice to be able to collect the evidence in advance.

Findings on each category of evidence

The following was learnt:

i) MSF

- The MSF would need to include specialty specific questions as well as generic questions. This is so that it shows other peoples' perceptions of an individual's performance as a whole and covers competence in all areas of the specialty.
- It must be completed by an appropriate range of assessors ie including peers (radiologists and other clinicians), trainees, patients, managerial staff, administrative staff, non-medical staff etc.
- A minimum number of responses should be defined.

ii) Discrepancy Meetings

- The requirements for this category should be made more explicit and attendance at meetings other than discrepancy meetings or morbidity/mortality meetings for interventionalists, eg audit meetings, should not be substituted. This is because it was felt to be very important that radiologists attend discrepancy meetings and reflect on their errors.
- Radiologists would need to show that they either regularly attend discrepancy meetings or, if they worked in a department that did not hold meetings, provide evidence that they were reflecting on errors and improving practice as a result.
- All discrepancy meetings should be conducted according to the RCR document: *Standards for Radiology Discrepancy Meetings (2)*.

iii) Evidence of Individual Performance in Practice

- This category appeared to cause the most problems for participants and, in some cases, participants struggled to provide sufficient evidence.
- It is important that there is sufficient range and quantity of evidence in this category.
- It should be stipulated that a minimum of five pieces of evidence over a five year cycle should be submitted.
- These should reflect the individual's normal areas of practice, which should be stated.
- There was some confusion as to whether data relating to the performance of the team could be submitted, or if it should be purely data on the performance of the individual. The group felt that two of the five pieces of evidence could relate to the team's performance but three must be specific to the individual.
- The RCR will look to develop tools to help radiologists provide evidence for this category, including:
 - Standards for peer review
 - Collating suggested/recommended audits relevant to self-assessment of performance
 - Use of e-learning – self assessment tools.

iv) CPD

- It would be important to include this as a professional requirement.
- The nature of CPD may change, depending on the final conclusions from the Department of Health, General Medical Council and Academy of Medical Royal Colleges. If so, this may need to be reflected in what evidence is required in this category.

Examples of good evidence that participants submitted include:

- External double reporting.
- The 'Performs' test undertaken by breast screening radiologists – this plots performance in a national co-ordinated film test on a ROC curve.
- An ultrasound audit – where a group of patients agreed to be scanned by two different members of the department so that all images and reports could be reviewed and cross-checked.
- Auditing results of reporting against MDT (multidisciplinary team) outcomes.
- Personal record of errors and resulting changes to practice.

Overall result

Taken as a whole, the group deemed this approach to have been successful, and, as long as the issues mentioned above were addressed, it should prove to be a practical, feasible and robust means of achieving recertification.

2. Analysis of the Evaluation Questionnaires

All participants were sent an evaluation questionnaire to complete and submit with their portfolio. The aim of the questionnaire was to find out how difficult and time-consuming it was to produce the portfolio, what participants would change about the process and whether they felt it was a viable framework to achieve recertification. 26 of the participants completed the pilot evaluation questionnaire.

A full analysis of the results of the questionnaires can be found in **Annex A**. In summary:

- The majority of respondents found completing the portfolio easy rather than difficult and 72% said it took them two hours or less to complete.
- Participants appeared to see the value in collecting evidence for all four categories of the pilot, although the MSF category came top in terms of usefulness.
- Evidence of individual performance in practice was felt by the majority to be the most challenging and difficult element of the pilot and, when asked what should be changed about the process, there were a number of comments from participants suggesting more detailed information and examples of the types of evidence needed for this category, with objective and measurable criteria, would be very helpful.
- 61% of those who responded felt they had done enough in completing the portfolio to demonstrate their fitness to practise. 26% said they had not and 13% were unsure.
- When asked whether they felt the portfolio approach would be viable framework to help clinical radiologists achieve recertification, 92% of respondents said yes. Practically all comments received in this question were positive, stating that this was a practical and manageable approach to recertification within a pragmatic and achievable framework, and that there was no feasible alternative. A caveat was sometimes added, however, that the requirements should be made more specific and protected time and appropriate secretarial support would need to be allocated.

As a whole, the questionnaire responses produced some very useful and constructive suggestions as to how the portfolio approach could be amended in future. Overall, the responses were very positive about using this approach as a viable framework for recertification.

I. Conclusion

The results of the pilot have proved to the RCR that the portfolio approach to recertification is both feasible and a practical way of helping doctors collate the appropriate evidence to achieve recertification. The assessment stage showed that the requirements for some of the categories needed to be strengthened or made more explicit and that there was a need for the College to develop tools, templates and examples of the types of evidence that should be included. However, with these caveats, the RCR believes that this approach is the correct one for its Fellows and members.

Furthermore, we have concluded that, once these tools are in place, it would be a process that could be administered and assessed locally, with the College playing an

advisory role in setting the standards and giving guidance to Fellows and members on how to achieve them.

J. Recommendations

The RCR's Recertification Committee would like to make the following recommendations based on this pilot:

1. That the portfolio approach is adopted as a feasible and practical way of achieving recertification.
2. That the RCR should now apply this same approach, which was piloted through the Faculty of Clinical Radiology with its Clinical Radiology Fellows, to its other Faculty of Clinical Oncology.
3. That both Faculties work on developing tools to help Fellows and members provide the evidence.
4. That the College's Patients' Liaison Groups continue to develop patient specific MSF.
5. That much consideration is given more widely to the practicalities of the assessment of the evidence submitted by doctors for revalidation. The administrative processes and the time taken to assess the portfolios for this pilot were considerable. The resourcing of this when it is rolled out nationwide will need careful thought and is certainly outwith the capabilities of this College.

K. References

1. Department of Health. *Trust, Assurance and Safety. The Regulation of Health Professionals in the 21st Century*. London, 2007
2. The Royal College of Radiologists. *Standards for Radiology Discrepancy Meetings*. London: The Royal College of Radiologists, 2007.

L. Acknowledgments

The RCR would like to thank the Academy of Medical Royal Colleges for providing funding for the pilot and 360 Clinical for their work on the Multi Source Feedback section.

Many thanks must also go to all those who volunteered to take part in the pilot, those who assessed the submissions and to the RCR's Recertification Committee and Clinical Radiology Recertification Working Party for developing the pilot and analysing the results.

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ANNEX A

Clinical Radiology Recertification Portfolio Pilot Analysis of Pilot Evaluation Questionnaires

26 participants completed the pilot evaluation questionnaire.

1. How difficult was it to complete the portfolio? (scale of 1 to 5, 1 being easy, 5 being difficult)

1	5 participants	(20%)
2	11 participants	(44%)
3	6 participants	(24%)
4	3 participants	(12%)
5	0 participants	(0%)

2. To the nearest hour, please estimate how long it took you to complete this portfolio (over and above preparation for your annual appraisal)?

1 hour	7 participants	(31%)
2 hours	9 participants	(41%)
3 hours	3 participants	(14%)
4 hours	2 participants	(9%)
5 hours	1 participant	(5%)

3. Which element(s) of the pilot do you feel were particularly useful and worth continuing with in the future? (Participants could tick more than one option.)

MSF	25 participants
Attendance at meetings	18 participants
Performance in practice	15 participants
CPD	21 participants

Comments

- 3 comments emphasized the importance of all 4 categories as they reflect actual working practice.
- There were 4 comments on how it was relatively simple to produce evidence for categories 1,2 and 4.
- 5 participants felt the MSF was very enlightening and the most important aspect of the portfolio.

4. Which element(s) were particularly challenging/difficult? (Participants could tick more than one option.)

MSF	1 participant
Attendance at meetings	4 participants
Performance in practice	18 participants
CPD	0 participants

Comments

The vast majority of comments (15) in this section found category 3 – individual performance in practice – the most difficult to complete. Many commented on how it was difficult to know what to submit as, in specialties other than breast and interventional, there is a very little objective evidence of performance. It was also felt to be the most time-consuming category.

There were 4 participants who found category 2 – attendance at meetings – difficult as attendance registers are not always kept, and those who are unable to hold or attend discrepancy meetings due to clinical demands found it hard to prove that they reflect on errors.

5. What would you change about the process?

Suggestions on what should be changed included:

- Protected time to complete the portfolio.
- Knowing evidence should be collected and retained in advance.
- More detailed information and examples of types of evidence needed for category 3 with objective and measurable criteria. This could include a formalised peer review process, double reporting etc. This may need to be adapted for different groups of radiologists.
- Templates could be produced for ease of completion eg attendance at audit, discrepancy meetings etc.
- Exam on the areas of normal practice would be the most robust method of recertification.
- Data required should be generated routinely and automatically.
- It could include a reference/testimonial from the employer.
- It could include a certificate from the Trust detailing patient complaints and outcomes against the individual.
- A job plan could be added.

6. Do you feel that in completing this portfolio you have done enough to demonstrate your fitness to practise?

Yes	14 participants	(61%)
No	6 participants	(26%)
Not sure	3 participants	(13%)

Comments

- Those who said yes did not really comment.
- Of those who said no, the comments made were that they were not sure the process would prove that someone was a competent radiologist, or reliably show if mistakes were being made.
- Amongst those who were not sure, a comment was made that standards need to be defined before they can be sure they have met them eg how many

audits should be carried out per year, a set number of peer reviewed cases per year etc.

7. Overall, do you feel the portfolio approach would be a viable framework to help clinical radiologists achieve recertification?

Yes	23 participants	(92%)
No	1 participant	(4%)
Not sure	1 participant	(4%)

Comments

Practically all comments were positive, stating that this was a practical and manageable approach to recertification within a pragmatic and achievable framework and that there was no feasible alternative. A caveat was sometimes added, however, that the requirements should be made more specific and protected time and appropriate secretarial support would need to be allocated.

8. Any other comments

The other comments made were:

- Good start to a very difficult process.
- Meaningful audit would be a better use of a radiologist's time.
- Would need to be carried out via an on-line process.
- Need to take into account sub-specialty interests.
- Very good start in current recertification/revalidation climate but it would be easy to be selective in the audits undertaken ie only look at aspects of your job that you know you do well and miss out aspects that are poor.