Malatest International

Evaluation report: End of Year 2014

Evaluation of the Regular Practice Review Programme

March 2015

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1. Executive Summary

The RPR evaluation provides mid-year and end of year evaluation reports. This report is the end of year 2014 report and updates an earlier interim report provided to the Medical Council of New Zealand in December 2014. The current report includes information from:

- Online survey responses from 93 of the 126 (74%) RPR doctors who received their RPR reports between July 2014 and March 2015
- Interviews with 14 RPR doctors
- Interviews with four collegial relationship providers
- Online survey responses from all 19 reviewers (100%)
- Interviews with six reviewers.

All doctors participating in RPR since June 2014 have been invited to be part of the evaluation though not all have chosen to take part.

1.1 Results

The participating doctors were primarily trained and working in general practice, though there was a smaller group who worked in other areas (for example, travel medicine or psychological medicine). They most often had between six and ten years of experience practising in New Zealand (29%), though more than one-quarter had more than twenty years of practice. More than one-third (39%) were trained in New Zealand and one-quarter (26%) in the UK.

Many of the responding doctors said they had had neutral or negative views about RPR before their practice visits. Doctors who were concerned about RPR most often commented they saw it as a 'box-ticking exercise' or were concerned that the RPR process would not work with the conditions of their practice. There was a common misconception that RPR was a pass/fail practice audit, rather than a process focused on improving quality of care through facilitating professional development.

Feedback from the surveys and interviews, completed after the doctors received their RPR reports, was generally positive. Taking part in RPR generally exceeded doctors' expectations. More than half (56%) agreed or strongly agreed that they would positively recommend RPR to their colleagues, a higher proportion than thought it would be useful before the visits (38%). More than two-thirds reported that the practice visit was a positive experience (70%) and caused them to reflect on their practice (73%).

It was important to the reviewed doctors that their reviewer had the appropriate skills and knowledge to evaluate their practice. The match between the reviewer and the reviewed doctor was often cited as a reason for the reviewed doctors' satisfaction or dissatisfaction with RPR as a whole. Overall, the majority of

participating doctors reported that their reviewer demonstrated the appropriate skills to evaluate their practice (75%).

Most doctors considered the RPR report findings accurately described their practice (68%). Half (50%) agreed that the report identified new opportunities to develop their practice. The small proportion of doctors who identified ways the reports could be improved, generally wanted more detail or more feedback from the reviewer.

Council's ultimate aim is for RPR to contribute to doctors improving the quality of care they deliver by facilitating professional development. Nearly two-thirds (60%) had made changes to their professional development plans as a result of RPR. Most doctors whose RPR reports had identified new areas for development had adjusted their professional development plans to target those areas.

Nearly half (44%) of doctors had already made changes to their practice as a result of RPR and a further 16% intended to make changes. Doctors described the changes they had made including improvements in self-care and self-management, reviewing prescribing practices, taking steps to improve interactions with patients and improving note taking.

Doctors who had learned about new strengths and new opportunities for development in their RPR reports were more likely to have made changes to both their practice and their professional development plans.

All reviewers reported that being a RPR reviewer was a positive experience for them and one that had personal benefits as well as contributing to their own professional development. Some commented on learning from the skills of the doctors they reviewed and being prompted to re-examine how they managed aspects of their own practice.

The RPR design is based on evidence and it is being effectively implemented although there could be more clarity for participants about the purpose of the review. The experience for participants and reviewers is generally positive. Reviewers are building up their experience in providing feedback and training aims to develop these skills. While many of the participating doctors have made changes to their practice, others may need further support to implement changes.

There are challenges in providing objective measures of outcomes but findings of the evaluation to date provide evidence of self-reported changes in practice and approaches to professional development for some participating doctors.

1.2 Points for discussion

The feedback from participating doctors was positive and it is clear that many of the reviewed doctors believe RPR has led to improvements in their practice. The

evaluation results have raised the following points for discussion that identify opportunities to continue the development of the RPR programme.

- **Clarity about the purpose of RPR:** RPR has been developed with a quality improvement focus. A common misunderstanding of the purpose of RPR, that it is a pass/fail practice audit rather than a process focused on improving quality of care through facilitating professional development, appears to be linked with dissatisfaction among the few doctors who were not positive about RPR.

  Seeing the review as an examination increases doctors' anxiety in the lead-up to RPR. For example, it exacerbates concern about the day of the reviewer's visit not being representative of the doctor's usual practice and concern that the doctor may not have sufficient expertise to assess the quality of practice.

- **Practice visits as a mechanism for change:** The majority of the reviewed doctors reported that the practice visits caused them to reflect on their own practice. This was also true for many of the reviewers who reported their own practice improved from carrying out reviews. Evidence from the literature supports the view that having independent observation has a benefit in itself. Doctors often reported that having an objective view of their practice was the most valuable part of RPR.

- **Collegial relationship provider role:** Doctors see and interact with their collegial relationship providers far more often and more routinely than their RPR reviewer. Doctors reported that they most commonly discussed their professional development with their collegial relationship providers. Interview participants' descriptions of their relationships with their collegial relationship providers varied.

  In some cases, the relationships involved a combination of informal discussion (by phone, email or in-person) of particular cases, formal and regular meetings to discuss the doctor's practice and involvement in peer review networks. Such relationships appeared to be of value in supporting the doctors' professional development and the CRPs felt that they were contributing to improvements in the doctor's practice. In other cases, the CRP relationship was not formal and there were barriers to open and honest communication, for example an employer-employee dimension.

  The effective CRP relationships suggest that the contribution to a doctor's development can be valuable. However, providing effective feedback and supporting change requires training and not all CRPs may have the skills or experience to provide the support required by colleagues.

- **Professional development:** One of the aims of RPR is to improve the way doctors engage with professional development activities and planning. In

response to the survey, one-third (34%) of doctors reported that they had discussed professional development with their RPR reviewer. Some of those who did discuss professional development with their reviewers reported that the discussion was more administrative (for example what to count as professional development and how to record it) rather than targeting the reviewed doctor's opportunities for development.

Developing the reviewer's ability to provide feedback on opportunities to develop the reviewed doctor's practice is likely to strengthen the effects of RPR on professional development.

- **Match between the reviewer and the reviewed doctor:** The match between the reviewer and the reviewed doctor in terms of seniority and area of practice were often mentioned by survey and interview respondents as reasons for their satisfaction or dissatisfaction. Given the small numbers of RPR participants and reviewers in atypical practices it is not feasible to match the reviewer's specialty area with the RPR participant. It is therefore important to ensure that the reviewed doctors understand the purpose of the review, how it applies to their practice, how the practice visit process can be modified to take the particular characteristics of their practice into account and why the reviewer is qualified to undertake the review.
- **Reviewer support and training:** The reviewers play a crucial role in the RPR process. They must have the appropriate skills to work with the reviewed doctor, gain their respect and deliver feedback in a way that is most likely to lead to improvement.

1.3 Evaluation next steps

The evaluation will continue to collect data from RPR participants as they receive their reports. In June 2015, a new survey will begin to collect feedback from doctors one-year after receiving their reports. It is expected that this survey will provide information on longer-term outcomes for doctors with a focus on understanding RPR's contribution to practice improvement.

2. Background to Regular Practice Review (RPR)

2.1 Establishment of RPR

One of the key roles of the Medical Council of New Zealand (Council) is to ensure that recertification programmes for all doctors are robust, help assure the public that the doctor is competent and fit to practise, and improve the current high standards of practice of doctors in New Zealand.[1]

Continuing professional development programmes (CPD) are one of the mechanisms professional organisations use to ensure the competencies of their members are maintained. For doctors, Council's aim is that all doctors (except those in vocational training) will have the opportunity to undertake a form of regular practice review that is a formative assessment. RPR has been implemented through the bpac^{nz} *inpractice* programme from July 2013. The programme design has been developed over the past two years by Council based on evidence from the literature, New Zealand experiences and discussions with stakeholders such as professional organisations.

RPR is a quality improvement process. Its primary purpose is to help maintain and improve the standards of the profession. The goal of RPR is to help individual doctors identify areas where aspects of their performance could be improved, benefiting not only their own professional development but also the quality of care that their patients receive. RPR may also assist in the identification of poor performance which may adversely affect patient care.

Council has introduced RPR as a mandatory requirement of the recertification programme for doctors registered in a general scope of practice. Many doctors registered in a general scope of practice tend to work in general practice with the remainder working in a range of specialties.

The funding for the RPR component of the Inpractice recertification programme comes from the annual fee general registrants pay to be part of the Inpractice programme.

[1] http://www.mcnz.org.nz/assets/Policies/Policy-on-regular-practice-review.pdf

3. The evaluation of RPR

As with any programme, it is important to assess the RPR programme to ensure it is working as intended and to understand outcomes for participating doctors. Council has commissioned an evaluation of the RPR programme to determine whether:

- RPR helps individual doctors identify areas of strength and areas of their practice that could be improved such as assisting in the planning of CPD
- Doctors act on the RPR report and make changes
- RPR helps assure Council that competence is being maintained
- RPR has any impact on the quality of care being delivered to patients
- RPR has any impact on indicators that suggest improved clinical outcomes.

The evaluation focus is on what is being achieved by RPR and responsibility for monitoring the effectiveness of the implementation sits with the service provider, bpac[nz].

3.1 The evaluation design

The RPR evaluation is based on the development of a logic model and evaluation framework that sets out the evaluation questions, the indicators and information sources (Appendix One). The evaluation framework was agreed with the Medical Council and provided the basis for the survey questionnaires and interview guides.

3.2 Information sources

Information included in this report was sourced from:

- Online survey responses from 93 of the 126 (74%) RPR doctors who received their RPR reports between July 2014 and March 2015
- Interviews with 14 RPR doctors
- Interviews with four collegial relationship providers
- Online survey responses from all 19 reviewers (100%)
- Interviews with six reviewers.

All doctors participating in RPR since June 2014 have been invited to be part of the evaluation. Doctors are invited to take part soon after they receive their RPR report and usually complete it within a month of the invitation. The highest proportion of the doctors who completed the online survey received their report in July-August 2014 (Figure 1).

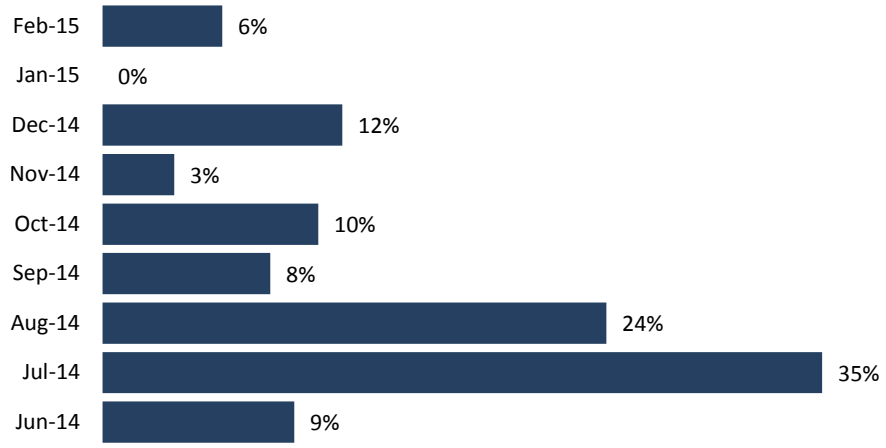


Figure 1. Proportion of survey respondent who received their RPR report in each of the months between June 2014 and February 2015 (n = 93).

The group of doctors who completed interviews were broadly consistent with those who completed the online survey in terms of their profile and their views on RPR, though the older age group (practicing for 40+ years was overrepresented amongst interviewees.

3.3 Strengths and limitations of the evaluation

The evaluation findings are based on the reviewed doctors' self-reported changes. At this initial stage of the evaluation there is no objective information about the extent changes have been made. At a later stage of the evaluation it will be possible to look at changes that are made to e-portfolios and data may be available to validate reported changes such as changes to prescribing and changes in multi-source feedback results.

The evaluation is based on surveys and interviews. Although the response rate from participating doctors was very good there is no information available about how non-responding doctors may differ to responding doctors. At a later stage of the evaluation it will be possible to compare the demographic profile of responding and non-responding doctors based on data provided by bpac^{nz}.

This report is of doctors included in the general practice cohort. Other professional groups may respond differently to RPR. Exploring any identified differences in findings across the different professional groups participating in RPR will be a focus of evaluation as the pool of participating doctors expands.

4. The participating doctors

The doctors who responded to the survey had been in practice for 1 to 52 years. Most commonly doctors had been in practice for 6 to 10 years (Figure 2). Five of the six doctors who had been in practice in New Zealand for less than five years were overseas trained.

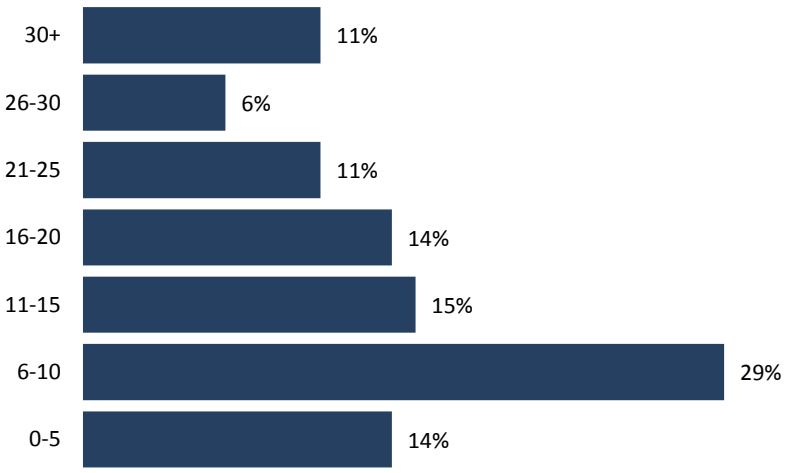


Figure 2. Number of years responding doctors had been in practice in New Zealand (n = 93).

More than half of the responding doctors completed their training outside New Zealand (Figure 3). English was not the first language for one-quarter (23%).

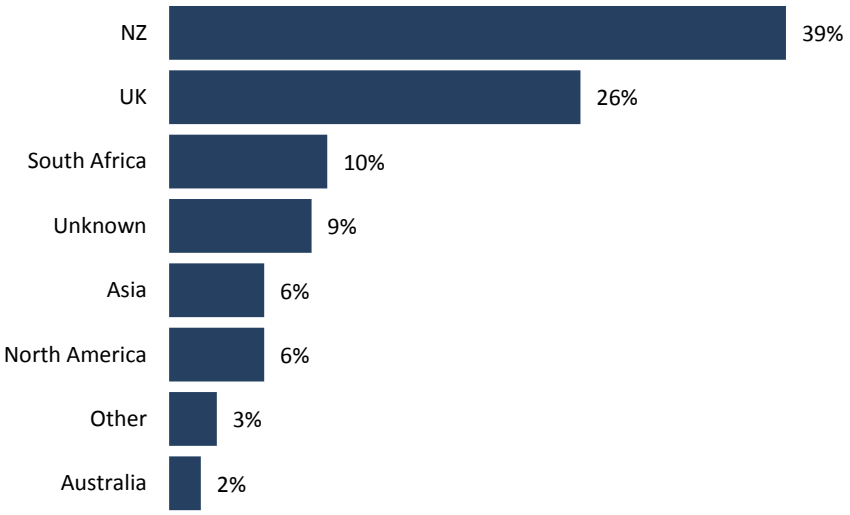


Figure 3. Locations that survey respondents completed their training. Where doctors identified more than one location, they were coded to the first mentioned (n = 93).

Survey respondents were asked to identify their current roles. Most (84%) said that they were General Practitioners but 16% gave other responses such as:

- Vein physician
- Medical director
- Senior house officer
- Skin cancer physician.

5. Doctors' preparation for RPR

Many of the responding doctors said they had had neutral or negative views about RPR before their practice visits. Doctors who were concerned about RPR most often commented they saw it as a 'box-ticking exercise' or were concerned that the RPR process would not work with the conditions of their practice. There was a common misconception that RPR was a pass/fail practice audit, rather than a process focused on improving quality of care through facilitating professional development.

The process of collecting multi-source and patient feedback was difficult for some doctors due to the conditions of their practice. Feedback from the tools was overwhelmingly positive.

Doctors were positive about the organisation and scheduling of RPR and some commented on the effectiveness of the bpac^{nz} contact.

5.1 Prior knowledge

The first doctors were invited to participate in RPR in July 2013 so the programme is relatively new. Some of the doctors interviewed knew nothing about RPR until they were invited to participate

> *[I had heard] nothing about RPR. The first I heard was when I reapplied for my licence and saw there was a thing called InPractice.*

Other doctors had heard of it but did not understand the purpose, requirements or what RPR involved.

> *I sort of vaguely knew. It was a bit confusing. I was confused about what they wanted. It's a new process so I didn't have other people to talk to about it. Some others had started the process but they were confused as well. There are questions about how to go about what you were expected to do.*

Others had heard about RPR and had a sense of what it involved. Some had colleagues who had participated in RPR already or who were involved in the process.

> *Had heard about it from a colleague at the conference in Rotorua about a year ago. One in the clinic had done it as well. He was preparing for RPR when he switched to do the fellowship.*

Overall, more than one-third of doctors who completed the online survey thought that RPR would be useful or very useful before they took part (Figure 4).

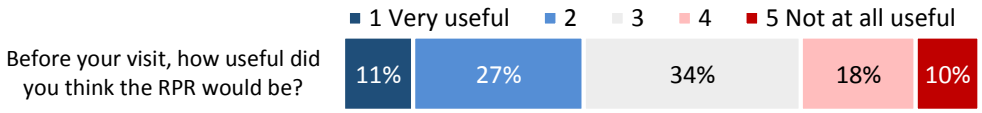


Figure 4. Doctors' reports of how useful they thought RPR would be before their practice visit (n = 93).

Figure 5 provides examples of why doctors thought the visit would be useful or not useful. Those who anticipated the visit would be useful welcomed the opportunity to discuss and receive feedback on their practice.

Very useful

I work in isolation so having a trained assessor observe and feedback on my patient interactions, record keeping and clinical/surgical procedures was likely to be very beneficial.

I felt this way as I understood this process to be supportive and objective. I strive for excellence and safety in my practice, therefore it was an exercise that I looked forward to and enjoyed.

To have some objective perspective on how I practice medicine.

I was unsure if anxiety may give a wrong appearance of my practicing.

Good to have someone come into the practice to review our systems ....somewhat tedious as we have three practice visits this year for fellowship, RPR, and cornerstone. Costly ...

Uncertain of the perspective of reviewer.

I find oral examinations threatening and stressful.

I'm an experienced, conscientious GP.... I'm confident that my methods of practice are safe and patient focused and I am medically up to date ....

The written info on the in practice website made it sound as if the visit would be about finding incompetent doctors and what the procedure would be depending on the degree of incompetence. I felt that this would be a very judgmental visit and of little 'use' to me other than ticking a box.

Not at all useful

Figure 5. Examples of doctors' reasons for believing RPR would be useful or not useful before their participation.

Interview comments suggest that doctors who did not understand the purpose were nervous and concerned about the experience. For example, one said:

> *I thought it would be more for the criticism rather than positive feedback. My impression was that they were there to observe you and criticise you not so much to improve you but to give feedback to InPractice that this person is worthy of a medical licence. Not there to teach new tricks but just to observe and give feedback on which ones are okay or not okay in terms of safety and style. They couldn't teach me anything in eight hours. What could they possibly teach?*

This misconception of RPR was common among the responding doctors. For example, one said:

> *I am an experienced GP of 35 years standing and had a whole tedious day where nothing was achieved. I think that there are other ways of assessing whether a doctor is fit for practice.*

Some comments showed relief when understanding after the visit that it was not an examination.

> *I say that it was not intimidating, did not feel that I was being tested or under pressure. It was certainly not like an examination. The quiz at the beginning was helpful to update many aspects of practice. I did not find the whole process onerous.*

As more doctors participate in RPR and it is more widely understood these misconceptions will become less common but they could also be addressed in the invitation and preparation stages for RPR visits.

Doctors' responses when asked what they hoped to get out of participating in RPR were similar. Some doctors hoped for constructive feedback as a result of the review process.

> *To identify any areas of relative weakness, especially indicated by a discrepancy between my own evaluation and that of my peers.*

Others were taking part in RPR only because they had to and referred to it as a box ticking exercise.

> *To tick yet another box to allow me to maintain my Annual Practicing Certificate.*

Some doctors were concerned that their practice was different to normal general practice and would not be suited to the review.

> *My work is very different from standard general practice and I often feel quite isolated - what I do doesn't fit with anyone in my peer group. I was looking forward to feedback, and hopefully also some validation.*

Some doctors were concerned about being able to interact with enough patients on the day of the review. For example, one did not work to appointments and could not be sure enough patients would attend on the day. Another worked in travel medicine and spent more time per consultation than the 15 minutes allowed in the plan. The reviewers handled these situations well on the day and showed enough flexibility. One reviewer said:

> *It worked okay. I was concerned that I wouldn't be able to get through enough numbers. It was discussed in advance. I thought if I didn't forestall that, I might fail. But they said it's fine and on the day the reviewer was flexible.*

Doctors were positive about the administration of the visits, including the scheduling and contacts with bpac^{nz}.

> *[bpac^{nz}] staff member was very easy to deal with.*

Overall, doctors were less likely to recall that before their visit they thought RPR would be useful than to say afterwards they would positively recommend it.

5.2 Feedback tools

The preparation for the practice visit component of RPR also includes a multi-source feedback round and/or a patient feedback round. Some doctors had difficulty completing these initial steps:

- Some did not understand what they were required to do.

I mean it wasn't positive or negative, when I heard about it. What was most confusing was what had to be done ahead of time. The multi-source feedback.

- Others had difficulty meeting the requirements for the number of colleagues or patients to complete the tools within their practice. The reasons given included being new to practicing in New Zealand, not having much contact with other health professionals in their role beyond referral letters and not having practices with typical GP interactions (for example, travel medicine doctors).

Getting [the multi-source feedback] done was difficult. I didn't have established networks. Finding ten colleagues in a short period of time was a challenge. There was some confusion about how that worked.

The questions in the questionnaire were very much based on general practice. It was hard to apply that to what I was doing.

The proportion of survey respondents who completed the patient feedback increased from 39% in December 2013 to 52% in March 2015. Overall, excluding those who did not use the feedback tools, doctors held similar views about the two tools with around half agreeing that they provided useful information (Figure 6).

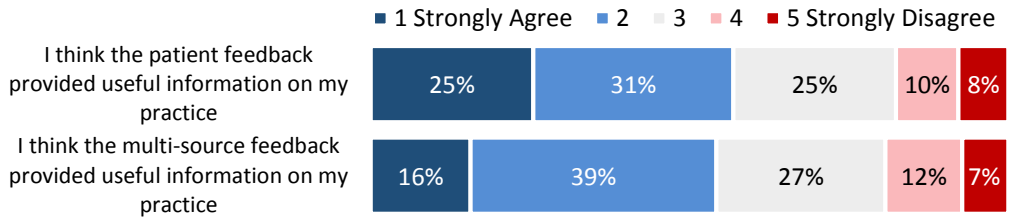


Figure 6. Survey respondents' views on whether the patient and multi-source feedback tools provided useful information about their practice (n = 93).

Patient feedback forms were completed by an average of 16 patients for each doctor and the overwhelming majority of ratings were positive. For example, only six out of the 252 RPR doctors had any patients give them a 'poor' rating when asked 'how good was your doctor at providing or arranging treatment for you today?' For all six, only one patient gave them a poor rating. The questions that most commonly had

any negative responses across all patients were confidence the doctor will keep information confidential (33 doctors with any negative responses), honesty and trustworthiness of the doctor (27 doctors) explaining your condition and treatment (16 doctors). These represent a very small proportion of the total number of patient feedback responses. Overall, only 19% of the doctors had any patients give a negative rating for any of the questions asked.

The twelve doctors who strongly disagreed or disagreed that the multi-source feedback was useful were more negative about RPR. All were working in GP roles, eight said they would not recommend RPR to a colleague and ten said they had not made changes as a result of RPR. Some doctors questioned the value of the feedback coming from the tools.

6. Participating in RPR

Feedback from the surveys and interviews, completed after the doctors received their RPR reports, was generally positive. Nearly two-thirds agreed or strongly agreed that they would positively recommend RPR to their colleagues, a higher proportion than thought it would be useful before the visits. More than two-thirds reported that the practice visit was a positive experience and caused them to reflect on their practice.

It was important to the reviewed doctors that their reviewer had the appropriate skills and knowledge to evaluate their practice. The match between the reviewer and the reviewed doctor was often cited as a reason for the reviewed doctors' satisfaction or dissatisfaction with RPR as a whole. Overall, the majority of participating doctors reported that their reviewer demonstrated the appropriate skills to evaluate their practice.

Most doctors felt that the RPR report findings accurately described their practice. Half agreed that the report identified new areas to develop their practice. The small proportion of doctors who identified ways the reports could be improved, generally wanted more detail or more feedback from the reviewer.

6.1 The practice visit

Survey respondents were generally positive about their experience of the practice visit with only a small proportion disagreeing that the practice visit was a positive experience (Figure 7). Results remain consistent with those from the preliminary evaluation report in December 2014 with the majority of doctors positive about aspects of their experience.

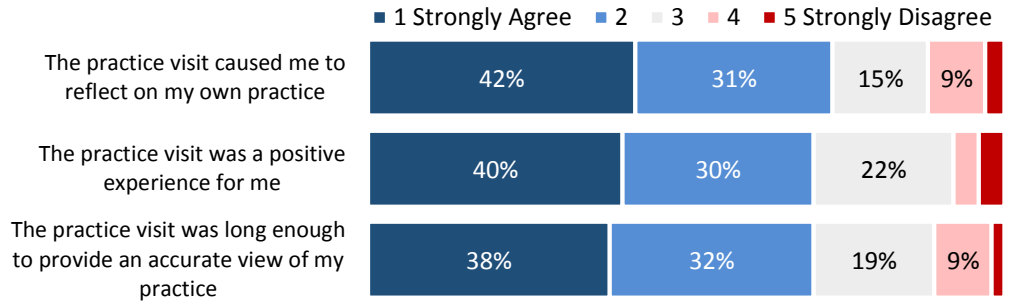


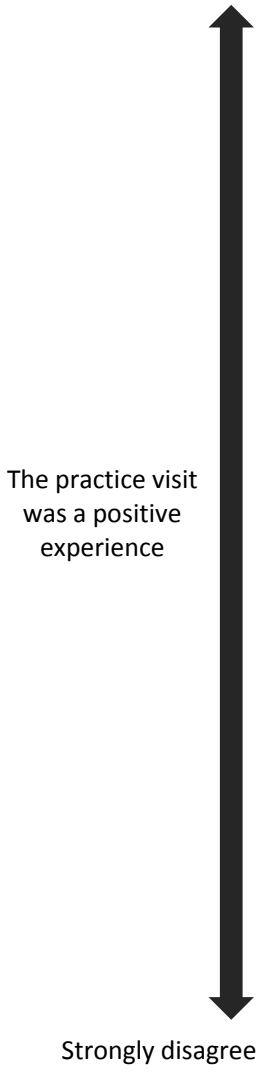
Figure 7. Survey respondents' views on their experience of the RPR practice visit (n = 93).

6.1.1. Most valuable aspects of practice visits

Comments about the most valuable aspects of practice visits focused on appreciation of the opportunity to receive feedback on their practice and to have a

discussion with the reviewer, and the effect of positive reinforcement in increasing the doctors' confidence in their practice. Practical tips were also noted as helpful. Many of the doctors who felt the practice visit was a positive experience commented on the collegiality, understanding and provision of constructive criticism by the reviewer. Having an objective view on their practice enabled self-reflection and was of benefit in itself.

Doctors' Examples of doctors' comments about the most valuable aspects of the practice visits are provided alongside their rating of whether they agreed the practice visit was a positive experience for them.



To have a chance of reflecting on my practice/the way I practise as a clinician, and to listen to senior doctor (reviewer)'s approach to each different clinical scenario.

The visitor's skill made the experience honest and collegial rather than inquisitorial and adversarial or judgemental. I accepted his suggestions as being given with my interest and that of my practice at heart.

Feedback from a experienced colleague, who help me to set up the goal of learning.

Being reassured that I am doing a good job, and am at the level I should be.

Good to have another practicing doctor review my practice. ....Very helpful suggestions by reviewing doctor.

None in particular stood out, with summary reached from a very small sample then extrapolated to broad generalisations.

It gave me generally positive feedback, this reflected my personal assessment of my practice. I feel the assessment could have been achieved via a video which would be less intrusive for patients. ... The RPR could then spend more time on review of clinical notes, recall practices, maintenance of records, management of acutely unwell patients, home visits, etc.

The reviewer told me I was competent (I had never had a reviewer in my consulting room giving feedback before). This gave me some confidence and reassurance.

In all honesty it was a waste of time with no reflection on the examiner as he did his part well.

6.1.2. Least valuable aspects of the practice visits

Although most doctors felt the practice visit was useful and a positive experience, some identified the aspects of the practice visit that were least valuable. Comments included:

- Disruption to the doctor's normal working day. This was a particular issue for locum doctors. One commented that she felt she was not fulfilling her contractual obligations on the RPR day as she was not able to see as many patients as usual. The time involved was also a frustration where a practice had multiple visits in a short time period.
- Some doctors expected RPR to focus on their clinical skills, for example their clinical reasoning, and were frustrated when feedback focused on process (for example note keeping).

Process is measured at the expense of content. There should be more technical appraisal of ability via the visit.

- The visit length was too short - Some felt that the short visit meant the reviewer was not able to allow a comprehensive assessment of their practice.

It seems artificial that an assessment of my practice can be based on a bit of a conversation and then seeing my assessment of a few patients.

- Some doctors had difficulty arranging for the right number of patients in practices that may not normally see that many.

6.2 The reviewer's expertise

Most doctors felt that the reviewer demonstrated appropriate skills to evaluate their practice (Figure 8).

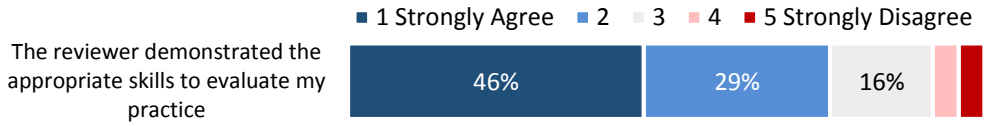


Figure 8. Responding doctors' views on the reviewers' skills (n = 93).

The reviewed doctor's understanding of their reviewer's expertise, experience in their area of practice and seniority were frequently cited as reasons for both satisfaction and dissatisfaction. Where the reviewed doctor did not see the reviewer as suitable there was often dissatisfaction with the experience as whole. The opposite was also true. For example:

Confirmed my standard of practice is acceptable although as the reviewer works in a very different setting from general practice I am not entirely confident of his awareness of GP challenges.

It was, for the reviewer, an unusual not a comfortable situation. She was not familiar with that kind of practice. She didn't really grasp what was going on.

My assessor was well versed in my particular area of practice and therefore had good insight and was able to provide useful feedback. I feel an assessment by a "generalist" would not have been as useful.

Some recognised that the reviewer could comment on the general aspects of their practice even if they were not experts in the specific area the reviewed doctor worked in.

The reviewer couldn't comment on my specific skills or the particular clients I work with but could discuss communication skills, record management, follow up etc - all the processes and skills common to all fields of medical practice.

Having a senior reviewer was also valued.

Participating in RPR gave me a chance of reflecting on my practice, and also gave me an opportunity to meet the senior doctor (reviewer) of the same medical field and listen to their advice about the way I should do my practice to improve patients' safety.

Doctors in some types of practice raised concerns about the impact of the presence of the reviewer on their patients, as well as the impact it had on their ability to perform as they normally do.

Most of the small number of RPR doctors who commented on whether the RPR process was how they expected it would be, said that the process was less onerous and less judgemental than they had expected. However, some did not enjoy the experience of having someone in the room observing their consultations.

Having a reviewer in the room was quite off putting and made it difficult to be my usual self. I think it is unnecessarily stressful and could be done less frequently.

There were a small number of comments on the inappropriateness of the reviewer's conduct.

The reviewer kept sighing during the consultations which intrusive.

The time spent was very much cut short. One starting time was a lot later than arranged. [Reviewer] was significantly late to the point where I was ringing and asking if [reviewer] was lost. Not aware of the reason for that. It had a huge impact on the schedule for the day. The patients start getting anxious and the pressure comes on. My job is to maintain equanimity. It proceeded sort of under tension. It wasn't relaxed.

At the end of each consult [the reviewer] made the comment "fine".

6.3 Reviewers' views on the practice visit

RPR reviewers agreed the practice visit was a positive experience for the RPR doctors and that doctors were receptive to their visits and the feedback they offered (Figure 9).

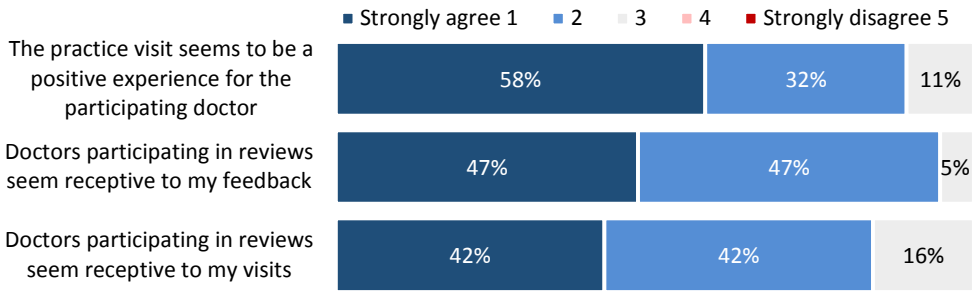


Figure 9. RPR reviewers' views on attitudes to the practice visit (n = 19).

Reviewers also considered the practice visit to be an effective tool for the RPR review (Figure 10).

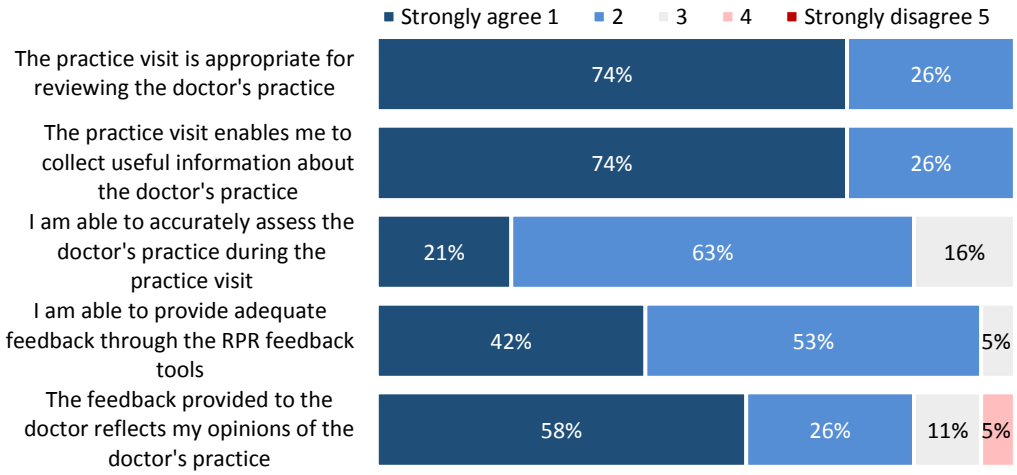


Figure 10. RPR reviewers' views on the effectiveness of the practice visit (n = 19).

Comments from reviewers indicated that in some cases the participating RPR doctors had not adequately prepared for the review with some noting RPR doctors' lack of self-review of their prescribing and laboratory reports.

> *My experience has been that many doctors are not taking the level of responsibility themselves that I would have expected around understanding what the visit involves, what is expected and being prepared for it. Quite a few have been "winging it".*

Some reviewers suggested changes to the booklet they used to record information about the practice visit such as adopting an electronic template for report back to bpac^{nz} (though this was available to reviewers) and having more room in the booklet to record information.

6.4 Overall views on RPR

Following their experience with RPR, more than half of the doctors agreed that they would positively recommend it to their colleagues (Figure 11).

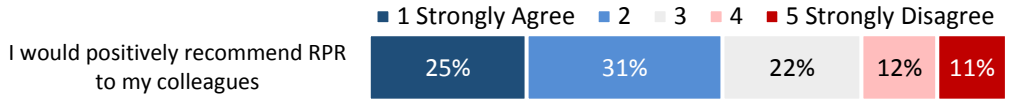


Figure 11. Survey respondents' agreement that they would positively recommend RPR to their colleagues (n = 93).

6.5 The RPR report

The RPR report is the formal mechanism for providing information back to participating doctors. RPR doctors were invited to take part in the survey approximately two-weeks after their RPR report was sent to them, so all had been emailed their report by the time they were invited to participate in the survey.

The majority of survey respondents felt that the RPR report was useful and accurately described their practice. They were less likely to agree that the report identified new opportunities for development or new areas of strength in their practice (Figure 12).

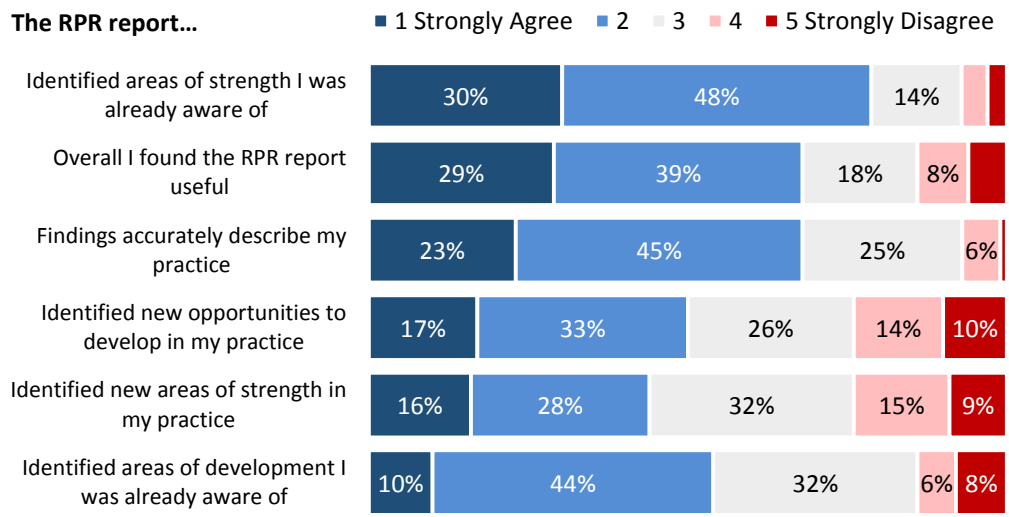


Figure 12. Survey respondents' views on their RPR reports (n = 93).

RPR report ratings show very few doctors received unsatisfactory ratings for any area of their practice that was rated by the reviewers. This supports feedback from interviewed doctors that the opportunities for development identified by the reviewers were generally not about correcting significant deficiencies that could raise concerns for patient safety but about improving already good practice.

Very small proportions of doctors received unsatisfactory ratings for any of the RPR report sections, and all unsatisfactory ratings were in the note and record keeping questions (2-3% unsatisfactory). No doctors received a negative ratings for fitness to practice, with just 1% receiving a neutral rating. Figure 13 shows the proportion of doctors who received a 'superior' rating (the nine point scale is divided into three sections: unsatisfactory, satisfactory and superior).

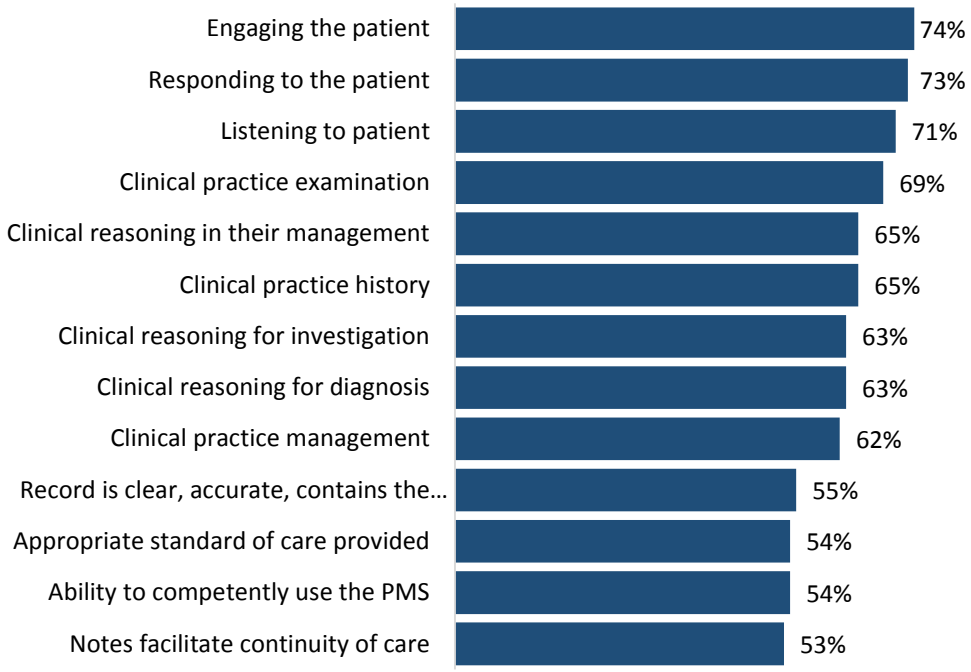


Figure 13. Proportion of doctors receiving the 'superior' rating for each of the RPR report rating questions (n = 252).

Encouraging doctors' development requires that they be made aware of opportunities for developing their practice as well as what steps they may be able to take to respond to those opportunities.

Overall, half (50%) of the responding doctors said that RPR identified new opportunities to develop their practice and almost all (85%) reported that it was clear what action they needed to take to address the development opportunities identified in the report.

Some doctors were disappointed with the report and just wanted more guidance on how they could improve their practice and for it to be presented more formally.

> *The writing wasn't very legible – loved the doctor, waiting with baited breath for the report and the writing wasn't very good. It's like a scoreboard. I would have liked a written report, typed up and signed. All the angst and work that goes into it, it was disappointing to get a brief hand written report.*

> *My approach to the whole process was as professional as anyone would expect, and this was noted by the reviewer. I found [the reviewer] pleasant, knowledgeable in general*

practice, and accommodating. I was therefore appallingly surprised when the reviewer's comments came back all but written in hand writing on the back of an envelope. They were difficult to read, poorly presented, arrived post a considerable delay, and looked as though no professional effort had been made at all. I was vastly disappointed and disillusioned by this.

Some doctors' emphasised the importance of the feedback in the report reflecting discussion on the day of the visit. One doctor commented:

Some things were criticised which the reviewer did not mention to me on the day. I felt upset that I had no chance to discuss these with the reviewer and that the criticisms were stated without describing the context of the consultation.

6.6 Reviewers' attitudes

Reviewers reported that their role as a reviewer was a positive experience for them, and one which most felt was respected by other doctors and valued by their profession (Figure 14).

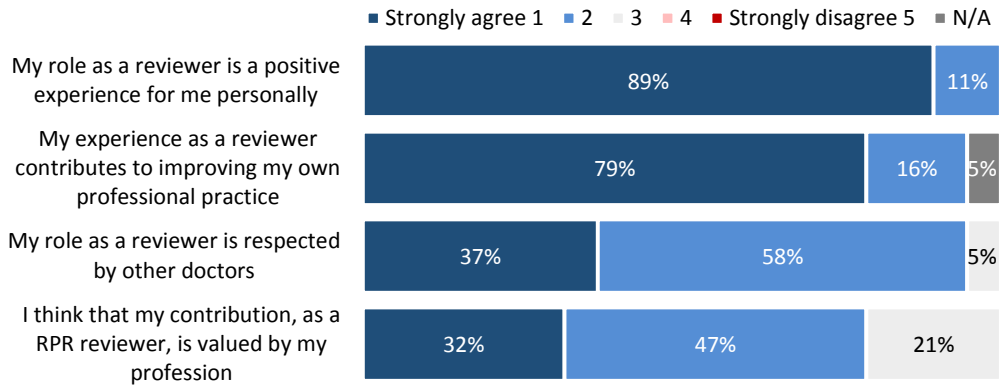


Figure 14. RPR reviewers' views on their role as a reviewer (n = 19).

Over three-quarters of reviewers strongly agreed that their experience as a reviewer had contributed to improving their own professional practice. Reviewers' comments are shown in the diagram below. Some commented on learning from the skills of the GPs they reviewed and being prompted to re-examine how they managed areas of their own practice.

Personal benefits	Professional benefits
Seeing a variety of different GPs in their practices and consulting has been extremely interesting.	I learn from the positives I observe in sitting through consults of my colleagues and use it in my own practice.
All the assessments to date have been a very pleasant experience.	Watching how other colleges manage conditions and which phrases that they use to explain conditions is always informative.
It has also been an opportunity to chew the fat over both ordinary and contentious issues and to hear fresh and diverse perspectives.	I too feel under the looking glass by those I review so it puts pressure on me to ensure I am really up to date so I appear credible.
It is inspiring to watch good doctors at work.	It gave me an opportunity to compare my practice with that of others and to hone my skills and make me a more efficient doctor.
I have also developed an increased positivity and optimism for General Practice.	Through my discussions, with doctors visited, about their Professional Development Plans, I have improved my own. More relevant, more specific. I have become aware of useful resources eg the Pegasus Treatment Guidelines and on-line resources to develop Cultural Competence.

7. Changes following RPR

Council's ultimate aim is for RPR to contribute to doctors improving the quality of care they deliver by facilitating professional development. Nearly two-thirds had made changes to their professional development plans as a result of RPR. Most doctors whose RPR reports had identified new areas for development had adjusted their professional development plans to target those areas.

Nearly half (44%) of doctors had already made changes to their practice as a result of RPR and a further 16% intended to make changes. Doctors described the changes they had made including improvements in self-care and self-management, reviewing prescribing practices, taking steps to improve interactions with patients and improving note taking.

Doctors who had learned about new strengths and new opportunities for development in their RPR reports were more likely to have made changes to both their practice and their professional development plans.

7.1 Changes to professional development

The person the highest proportion of respondents discussed their professional development plans with was their collegial relationship provider (Figure 15).

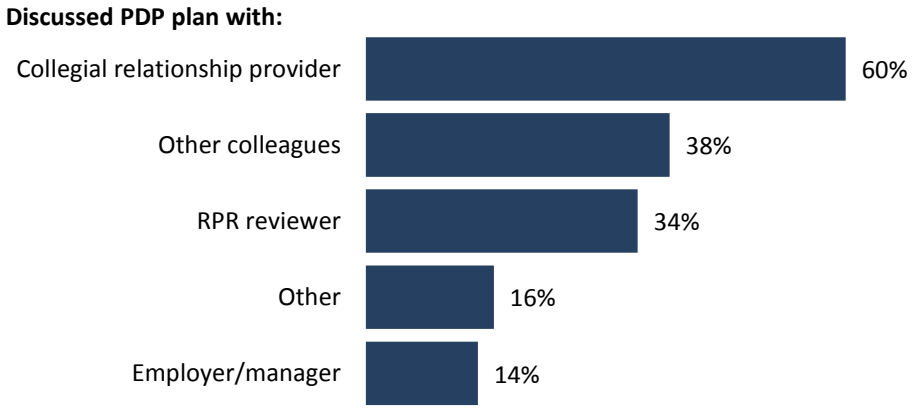


Figure 15. Proportion of doctors who discussed their professional development plans with different groups (n = 93). Note that doctors were able to select more than one option.

One-third (34%) of doctors discussed their PDPs with their reviewers. Doctors gave mixed feedback on their use of their e-portfolios with close to half agreeing that they updated their e-portfolio at regular intervals and that their e-portfolios are useful tools to improve practice (Figure 16).

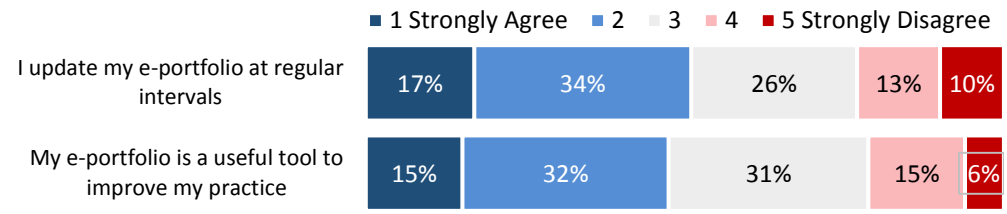


Figure 16. Doctors' views on their e-portfolios (n = 93).

Overall, around half of the responding doctors planned to adjust their PDPs based on the results of RPR (Figure 17).

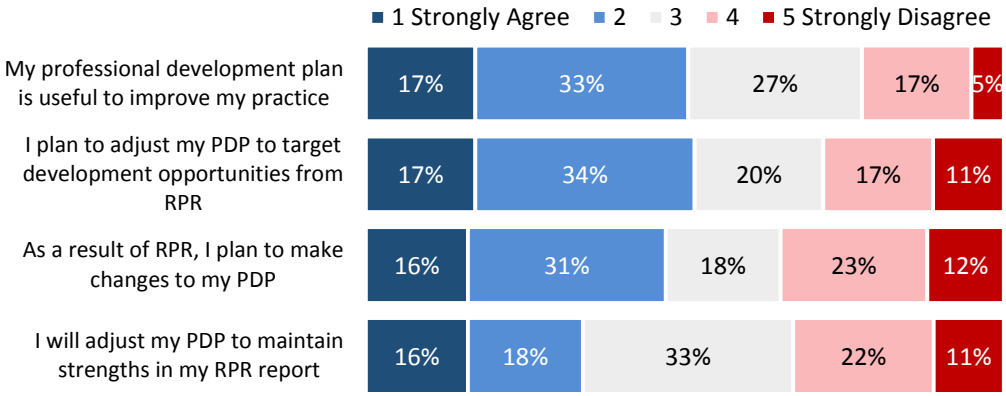


Figure 17. Doctors' views on their professional development plans (n = 93).

As noted in section 6.5, half (50%) of the responding doctors said that RPR identified new opportunities to develop their practice. Of those doctors:

- Almost all (87%) planned to make changes to their PDPs (compared to 43% of other doctors)
- Almost all (90%) planned to adjust their PDPs to target the development opportunities identified in their RPR report (compared to 22% of other doctors)

More than half of the doctors who responded to the survey had already made changes to their PDPs as a result of their participation in RPR (Figure 18). This proportion increased from 53% in December 2014 to 60% in March 2015.

Figure 18. Proportion of responding doctors who had and had not already made changes to their PDPs as a result of their participation in RPR (n = 93).

Some responding doctors described the changes they had made to their professional development including:

- Attending training to improve cultural competence
- Entering vocational training

I intend to start specialist training within the next few months.

- Improving their management of their professional development.

I have added several PDP goals in my e-portfolio.

I was told what sorts of goals are expected so have adjusted them accordingly even though I don't think that this is the right way for me to learn and am likely in practice to continue doing things the way that works for me.

I record my CPD activities more frequently and link them to PDP goals. This is purely an administrative improvement. It has no other useful function.

A small proportion of the responding doctors said that their RPR reports identified new opportunities for development but they did not plan to adjust their PDPs. Only one of these doctors commented:

I discussed the process with other colleagues who were also confused about the process and hopefully have come to some idea about how to make the tool a more useful process.

7.2 Change to practice

Overall, nearly half of the responding doctors said they had already made changes to their practice as a result of participating in RPR and a further 16% intended to make changes (Figure 19). The proportion who had made practice changes decreased slightly from 51% to 44% between the December 2014 report and this report, with a corresponding increase in the proportion who intended to make changes (9% to 17%).

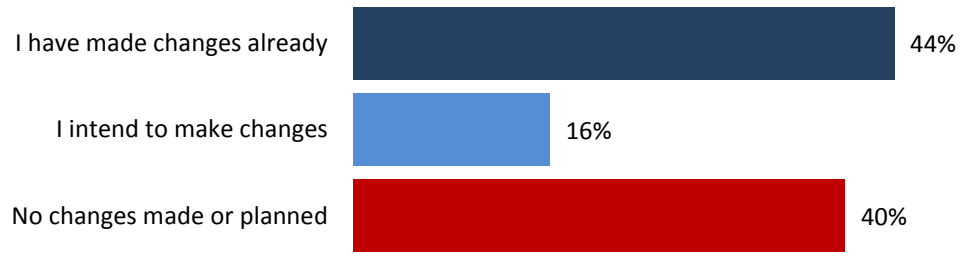


Figure 19. Proportion of survey respondents who had made changes already, who intended to make changes (but had not already done so) and who did not intend to make changes (n = 93).

Around half believed that participating in RPR had helped them improve the care they deliver to their patients and had helped them improve their practice in other ways (Figure 20).

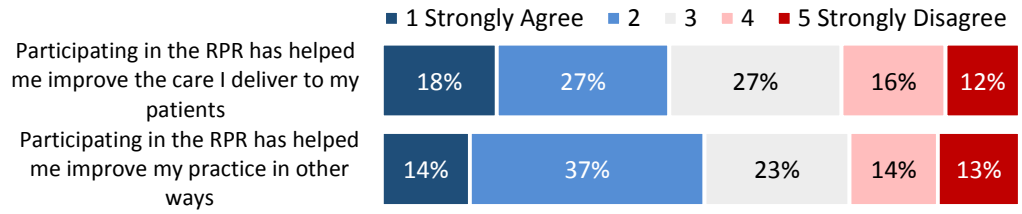


Figure 20. Survey respondents' views on the impact RPR has had on their practice (n = 93).

Examples of changes included specific improvements in consultation style and interaction with patients, improvements to note taking and prescribing habits and better use of resources. Some comments from participating doctors are provided in Table 1.

Table 1. Examples of comments made by doctors positive or negative about RPR describing the changes they have made as a result of participating in RPR. Comments mentioned more often are listed higher in the table.

Positive about RPR	Negative about RPR
Improved notes and record keeping: *Improved patient records and notes* **Changed how consult is managed:** *A better ending to consultations with a clear plan of what the patient should do regards follow up & continued care.* **Review prescribing:** *I have reviewed my prescribing.* **Listen to patient more:** *Taking more time to listen to patients initially during the consult as advised by RPR.* **Give patients more resources (including written instructions and pamphlets):** *Incorporation of more patient information resources.* **Improve e-management:** *Discussed fuller use of med tech e.g. classifications for the whole institution I work for.*	**Review prescribing:** *Reviewed prescribing practices.* *Reviewed my prescribing of Augmentin and have looked for other appropriate antibiotic alternatives. I thought this a most valid critique, and when discussed without CME group of some 16 doctors we all accepted we all need to do this.* **Improved notes and record keeping:** *Reviewed notes of applicable patients and recalled for consideration.* **Review lab tests ordered:** *I am a bit more critical about which lab tests I order.* **Wash hands more:** *I wash my hands regularly.* **Improve e-management:** *I put extra things at the bottom of my screen.* *Reviewed own practice: reviewed prescribing practices, reviewed notes of*

Utilise more resources in practice (online): *Aim to include more online resources including questionnaires for CME purposes.* **Audit clinical record:** *Starting audit my clinic record and make a protocol to avoid the chance of missing document.* **Improving cultural competence:** *Taking specific interest in Maori and pacific cultural aspects of patients and trying to integrate them in consultations.*	*applicable patients and recalled for consideration.*

7.3 Reviewers' perspectives about change

The majority of RPR reviewers thought that the RPR process will enable doctors to make changes to their practice and that RPR will contribute to improving the care delivered to patients (Figure 21). In interviews, reviewers commented that it would be good to have some follow-up with the doctors they reviewed to see what changes had been made.

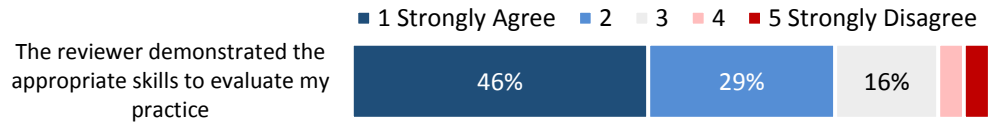


Figure 21. Reviewers' views about changes following the RPR process (n = 19).

7.4 The CRP role

Collegial Relationship Providers (CRPs) play an important role in providing feedback and supporting the professional development of general scope doctors, including those participating in RPR. CRPs are required to be:[2]

- role models of good medical practice
- sounding boards for the doctors' ideas
- resources in times of difficulty.

Their key role is to help develop a CPD plan each year. They may also facilitate:

[2] From the Medical Council Website. Accessed at: https://www.mcnz.org.nz/maintain-registration/recertification-and-professional-development/collegial-relationships

- random auditing of a specified number of clinical records in any one calendar year and giving feedback on areas for improvement
- observing a specified number of consultations in any one calendar year and giving feedback on areas for improvement
- helping the doctor in any other mutually agreed way to enhance his or her practice skills and personal growth.

Nearly two-thirds (60%, refer to Figure 15) of the doctors who responded to the online survey had discussed the PDPs with their CRPs, leaving a large proportion who had not. This suggests variation in the quality and effectiveness of the CRP relationship which was supported by comments in interviews with reviewers and doctors.

The RPR reviewers held mixed views about the effectiveness of the CRP role. Many found that the RPR doctor and the CRP had a less structured relationship than expected and some suggested contact with the CRP before and/or after the practice visit.

> *The doctors who are providing their collegial relationship have usually not even been using the InPractice site at all or even know how to log in. I have found it often difficult to contact them.*

However, some of the interviewed doctors described effective CRP relationships confirmed with interviews with the CRP. For example, one doctor had a relationship with a senior colleague who used to work in the same practice. They participated together in a registered peer review group, met approximately once every two months for formal CRP meetings including discussions of professional development and more frequently exchanged informal emails about individual cases or developments in their field of practice. The CRP believed she contributed to improving the doctor's practice:

> *I think [I contribute to improving her practice], because of her circumstances doing GP work and Locum work I'm a continuous thread through that. It gives her a point of contact if she has any problems. She's always open to discuss cases, to learn and to admit or recognise when she's out of her depth.*

7.5 Groups of doctors more likely to report having made changes

It is important to note that the findings in this section rely on doctors self-reporting changes in their practice and their professional development plans. Examination of these key outcomes from RPR shows that there are some significant differences:

- Doctors who learned both new strengths and new weaknesses as a result of participation in RPR were significantly more likely to report having changed their practice ($F(3,89) = 13.23$, $p < 0.001$), to be more likely to positively recommend RPR to their colleagues RPR ($F(3,89) = 4.16$, $p < 0.01$), and to

have made changes to their professional development plans ($F(3,89) = 7.24$, $p < 0.001$).

- Years practicing in New Zealand, country of training and current role did not have a significant effect on doctors' likelihood to have made changes, to positively recommend RPR or to have learned about both new strengths and weaknesses in the RPR report.
- Doctors who spoke English as a second language were more likely to agree that they had already made changes to their practice as a result of RPR ($t(91) = -2.23$, $p < 0.05$) though no significant differences were found in other areas.
- Doctors who would not positively recommend RPR to their colleagues were less likely to have learned new strengths and weaknesses in their RPR reports ($t(91) = 3.55$, $p = 0.01$) and more likely to have made changes to their practice ($t(91) = 4.76$, $p < 0.001$), though there was no difference in likelihood of having made changes to their professional development plans.
- Doctors who had already made changes to their professional development plans were more likely to have made changes in their practice ($t(91) = 6.161$, $p < 0.001$).

Table 2 below presents the differences in proportions between the groups of doctors in the survey, though note that differences not noted above are not significant. As more responses are collected, more differences may emerge or become significant.

Table 2. Proportion of respondents with certain characteristics who had already made changes to their PDPs at the time of the post-RPR survey (n = 93).

	Number of respondents	Have made changes to their PDP	Have made changes to their practice	Would recommend RPR to their colleagues
English as a second language	21	76%	62%	76%
English as a first language	72	56%	39%	50%
Less than 10 years in practice in NZ	40	50%	35%	55%
11-30 years in practice in NZ	43	67%	51%	58%
30+ years in practice in NZ	10	70%	50%	50%
Current role as a GP	77	58%	40%	52%
Other current role	16	69%	63%	75%
Learned nothing new in their report	40	38%	29%	28%
Learned both new strengths and weaknesses	35	86%	71%	89%
Trained in NZ	35	57%	40%	48%
Trained elsewhere	58	62%	47%	62%

8. The RPR Reviewer Role

While some reviewers were new to the role, others had previously worked as reviewers in New Zealand or overseas. Almost all reviewers felt they had the necessary training, support and information about the doctor to be effective reviewers.

Many reviewers were still developing in their roles. Most wanted about one review a month to provide them with confidence and to be able to benchmark the doctors they reviewed. Aspects of reviewer development suggested by the evaluation are:

- Confirming the effectiveness of their collegial approach to RPR as a quality improvement process
- Confirming that they are effective as reviewers even when the doctor being reviewed has a different scope of practice to their own
- How to provide feedback and advice that would assist RPR doctors to use information from the review to make changes.

The expertise of the reviewers underpins the effectiveness of the RPR process. Reviewers were recruited through advertising and provided with training and workshops to develop their skills as reviewers.

8.1 Reviewer training and preparation

At the time of the interviews, RPR reviewers generally felt they had the necessary support and training to carry out effective reviews and had sufficient information about the doctor being reviewed (Figure 22).

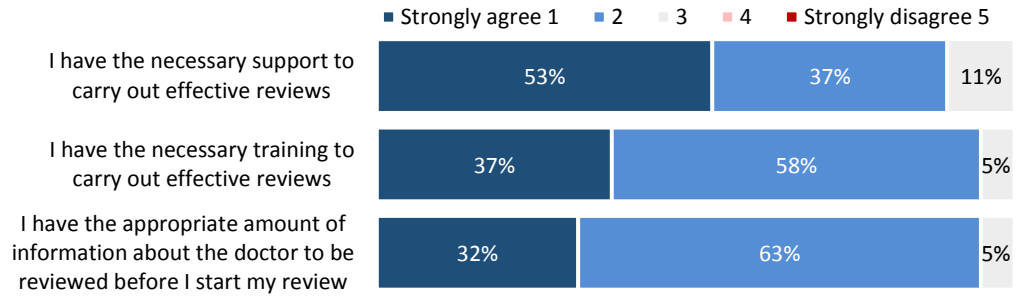


Figure 22. Reviewers' views on their preparation for the reviewer role (n = 19).

8.2 Reviewer workload

Two-thirds of the reviewers ideally wanted to complete more reviews in the next 12 months than in the past 12 months (Figure 23). None of the reviewers wanted fewer reviews.

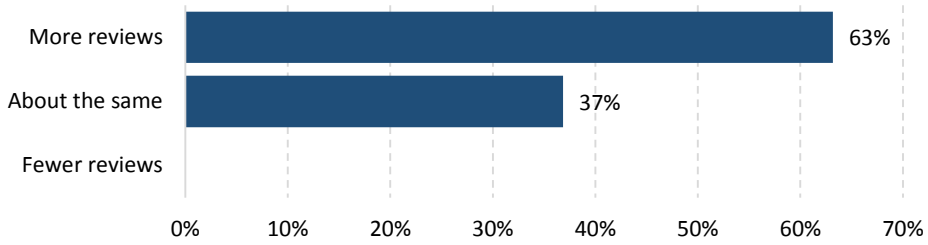


Figure 23. RPR reviewers views on if they would like to do more reviews in the next 12 months (n = 19).

The ideal number of reviews seemed to be between nine and 12 each year (Figure 24). Four reviewers had completed 13 or more reviews over the past 12 months. A reviewer explained that this number of reviews gave reviewers the opportunity to stay current and to benchmark the reviews they completed against each other.

Figure 24. RPR reviewers' views on if they would like to do more reviews in the next 12 months broken down by the number of reviews done in the last 12 months (n = 19).

8.3 RPR reviewer suggestions for changing and developing the role

Reviewers were still developing in their role as reviewers but had completed a sufficient number of reviews to comment on what was working well and what they found difficult.

A common request was for feedback about how they were doing as reviewers, how the feedback they provided compared with that from other reviewers and what RPR doctors thought of the review experience. Reviewers noted the responsibility they felt to be effective as reviewers and the importance of the reviewers having credibility with the reviewed doctors. In this context some reviewers noted that they found it difficult to review doctors when:

- They did not see a range of consultations
- They were reviewing doctors who were practicing in specialty areas

I have found it more difficult to satisfactorily assess doctor's competence in specialty areas of practice, in which I have little experience.

- Doctors who consulted in a language other than the reviewer's language

Suggestions by reviewers to improve the review process included:

- Contact with the collegial relationship provider prior to the review visit.
- A pre-visit discussion with the doctor being reviewed to provide an outline of what would be discussed and encourage self-reflection by the doctor prior to the visit.
- An opportunity to follow through on the discussions they had as part of the review to see if the participating doctors had made changes as a result.

I have tried to make helpful suggestions at all visits which could improve practice, but have no idea whether the doctor will act on any of them. Some have asked if they will be reviewed by the same person in the next round. It would be most beneficial to at least have access to the previous report if we are making the next visit so that some monitoring of action on previous recommendations could be made. Or the collegial relationship provider could formally become involved in ensuring action on any points raised following the visit.

One of the restrictions on the activity of reviewers, imposed by the Medical Council, was that reviewers were not to review doctors from the same area. This limitation means that reviewers must all travel to complete each review, which is an increased cost in terms of reviewer time and travel. Some reviewers wanted to do reviews in their own area, however, allowing that could increase the risk of conflicts of interest which could reduce the ability of RPR to achieve the Medical Council's objectives.

The skills of the reviewers continue to be developed by bpac^{nz} through investment in training sessions and the reviewers identified some other opportunities for improving their expertise. Examples included:

- Review of reviewers, including feedback on their reporting and the reviews they had completed
- The need to be reviewing regularly to maintain consistency over time
- More understanding of what happens when a problem is identified, how that is followed up with the doctors and what actions are taken to address the problem
- Ensuring the professional credibility of other reviewers
- Quick links to resources that reviewers could use in discussions with RPR doctors during practice visits, for example guides on professional development opportunities and tools doctors can access.

9. Points for discussion

The feedback from participating doctors was positive and it is clear that many of the reviewed doctors believe RPR has led to improvements in their practice. The evaluation results have raised the following points for discussion that may identify opportunities to continue the development of the RPR programme.

9.1 Understanding the purpose of RPR

As discussed in section 5.1 the most common misconception was that RPR was intended as a pass/fail audit of their practice, rather than a process focusing on improving quality of care through facilitating professional development. The risk is that as doctors are not used to performance appraisal, they could see RPR as a threat rather than an opportunity to learn and to improve (Wallis, 2014). In a qualitative study, Pelgrim et al. (2012) found that apprehension about being observed and receiving feedback proved to have a powerful negative effect on feedback for postgraduate general practice medical trainees.

Misconception about the purpose of RPR increased doctors' anxiety in the lead-up to the review. For example, it exacerbates concern about the day of the reviewer's visit not being representative of the doctor's usual practice and concern that the reviewer may not have sufficient expertise to assess the quality of practice.

Doctors are provided with information about RPR in the lead up to the visit and the purpose of RPR will become more well-known as it becomes more embedded. There may be opportunities to increase understanding of the purpose of RPR for doctors as they are invited to participate and among the medical community as a whole. Increased understanding could increase satisfaction amongst the few doctors who were not positive about RPR after their reviews.

9.2 Practice visits as mechanisms for change

RPR aims to contribute to continuous improvement in doctors' practice and in their approach to professional development. The written RPR report presenting the results of each doctor's review is expected to be a mechanism for change. Doctors' feedback highlighted the importance of the practice visit as a quality improvement tool with doctors' comments suggesting a practice visit prompted self-reflection that was valuable in itself.

Doctors in general practice interact with patients on a 1:1 basis and rarely have opportunities for independent observation or objective feedback. Doctors in group practice may be aware of the standard of their colleagues' work but there are often no mechanisms for formal feedback. For many of the reviewed doctors, having an

objective view of their practice from a knowledgeable and respected colleague was valuable even to confirm that they were doing a good job.

> *Participating RPR gave me a chance of reflecting on my practice, and also gave me an opportunity to meet the senior doctor (reviewer) of the same medical field and listen to their advice about the way I should do my practice to improve patients' safety.*

There is evidence that audit and feedback can improve practice and patient outcomes. Jamtvedt et al. (2012) conducted a systematic review of trials examining the effect of audit and feedback on improving patient outcomes and professional behaviour. They found that the effect varied widely across studies ranging from little or no effect to substantial effect. The review concluded that audit and feedback generally lead to small but potentially important improvements, but effectiveness is linked to baseline performance and how feedback is delivered. It was most effective when:

- The health professionals are not performing well at baseline
- The person responsible for the audit and feedback is a supervisor or senior colleague
- It is provided more than once
- It is given both verbally and in writing
- It includes clear targets and an action plan.

It is important to note that most studies included in the review focused on interventions targeting specific clinical behaviours rather than taking the broader approach of RPR.

Miller and Archer (2010) carried out a systematic review of studies testing the educational or performance effects of workplace based assessments for doctors. Their findings, primarily based on comparative descriptive or observational studies, showed that multi-source feedback can lead to performance improvement but the context and facilitation of the feedback were influential on the degree of improvement. The feedback was more likely to increase performance if it was credible and accurate and if the process included coaching to identify their strengths and weaknesses. They concluded that while there was no evidence that other workplace based assessment tools (including direct observation and case based discussion) lead to improvement in performance subjective reports on their impact were positive. There is a lack of robust study designs able to show conclusive links between workplace based assessment and performance improvement (Miller and Archer, 2010).

O'Brien et al, (2008) conducted a systematic review on the effectiveness of educational outreach visits to healthcare professionals, which were defined as personal visits by a trained person to health professionals in their own settings targeting a specific outcome. The authors concluded that outreach visits had small

but consistent effects on prescribing but the effect of outreach visits on other types of professional performance was found to vary between studies from small to modest improvements. The reasons for differences could not be explained.

The findings of Jamtvedt et al. (2012) suggest that a senior colleague, respected by the doctor, is ideally placed to provide effective feedback. Collegial relationship providers give the doctors feedback on a more regular basis than RPR occurs. As noted in section 7.1, the reviewed doctors most commonly discussed their professional development with their collegial relationship providers. There was variation in the quality of relationships described by the reviewed doctors and by the CRPs interviewed. In some cases, the relationships involved a combination of informal discussion (by phone, email or in-person) of particular cases, formal and regular meetings discuss the doctors' practice and involvement in peer review networks. Such relationships appeared to be of substantial value in supporting the doctors' professional development and the CRPs felt that they were contributing to improvements in the doctors' practice. In other cases, the CRP relationship was not formal and there were barriers to open and honest communication, for example an employer-employee dimension. Providing feedback and support that leads to change is a skilled process and not all CRPs may have the appropriate skills or experience to do so.

9.3 Professional development

One of the aims of RPR is to improve the way doctors engage with professional development activities and planning. In response to the survey, two-thirds of doctors reported that they did not discuss professional development with their RPR reviewer. Some of those who did discuss professional development with their reviewers reported that the discussion was more administrative (for example what to count as professional development and how to record it) rather than targeting the reviewed doctors' opportunities for development.

Developing the reviewers' ability to provide feedback on opportunities to develop the reviewed doctors' practice is likely to strengthen the effects of RPR on professional development.

9.4 Follow up after the review

Some reviewers expressed the view that they should have an opportunity to contact the doctors again to follow-up on the feedback they provided doctors. Some reviewers also felt that there should be some check-up to ensure that action had been taken to address their concerns. Some of the reviewed doctors held the same view, particularly where they were surprised by the comments of the reviewer or where they disagreed with the comments. For example, follow-up could focus on

discussing ways to incorporate activity focusing on using professional development plans to address the opportunities for development identified in doctors' RPR reports.

One option is to incorporate the follow-up role into the collegial relationship of the reviewed doctor. The CRP is involved in the review process and all CRPs interviewed had discussed the reviewed doctors' RPR reports with them. This change alongside strengthening the CRP role could be an opportunity for development though questions about training and funding for this would need to be addressed.

9.5 Match between the reviewer and the reviewed doctor

The match between the reviewer and the reviewed doctor in terms of seniority and area of practice were often mentioned by survey and interview respondents as reasons for their satisfaction or dissatisfaction. As noted above, feedback is most effective when it comes from a senior colleague so it is important that the reviewed doctor respects the reviewer.

Given the small numbers of RPR participants in atypical practices it is not feasible to match a reviewer's specialty area with the RPR participant. It is therefore important to ensure that the reviewed doctors understand the purpose of the review, how it applies to their practice, how the practice visit process can be modified to take the particular characteristics of their practice into account and why the reviewer is qualified to undertake the review.

Misunderstanding the purpose of the review (seeing it as a pass/fail practice audit) appears to contribute to reviewed doctors placing a high importance on the expertise of the reviewer in their area of practice. Ensuring that the reviewed doctors understand the purpose of the practice visit and RPR as a whole could address this problem.

9.6 Reviewer support and training

The reviewers play a crucial role in the RPR process. They must have the appropriate skills to work with the reviewed doctor, gain their respect and deliver feedback in a way that is most likely to lead to improvement. Effective feedback is feedback in which information on previous performance is used to promote positive development. It should be planned, delivered in an effective manner and be incorporated into the learning process by relating it to learning goals and plans for improvement (Archer, 2010). Ensuring that the reviewers are trained to deliver feedback effectively on the day is important. Some doctors highlighted the discussion with reviewer about findings as one of the most valuable aspects of RPR and doctors made negative comments when they found feedback in the report that

they had not already discussed with the reviewer. Ensuring that the feedback is given in an effective manner and that the next step, how it can be incorporated into professional development plans, is discussed could be a way to increase the impact of RPR.

9.7 References

Archer J (2009) State of the science in health professional education: effective feedback. Medical Education (44)1.

Jamtvedt G, Ivers N, Flottorp S, Young JM, Odgaard-Jensen J, French SD, O'Brien MA, Johansen M, Grimshaw J, Oxman AD (2012), Audit and feedback: effects on professional practice and healthcare outcomes (Review), The Cochrane Library, Issue 6.

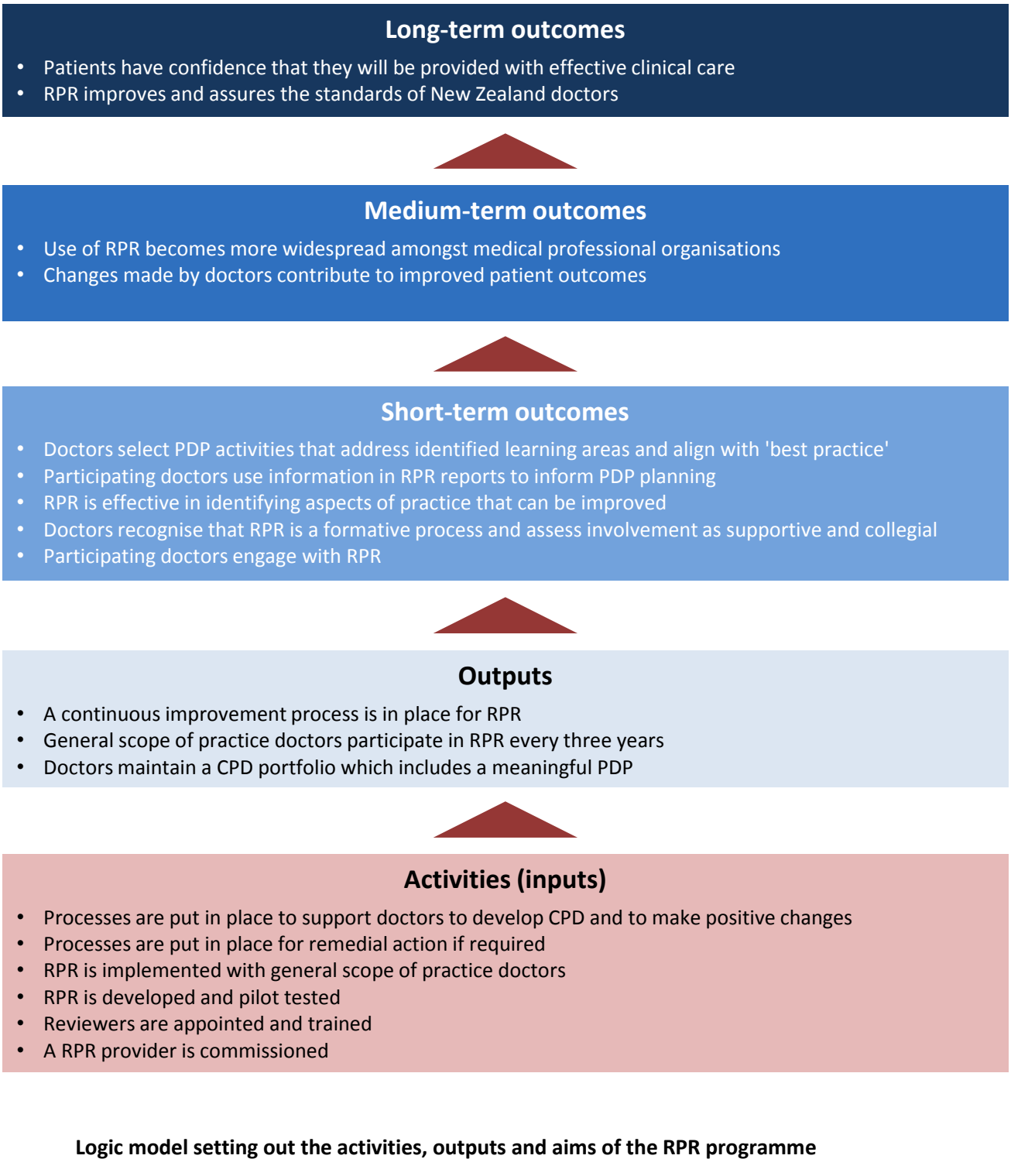
Miller, A, Archer, J (2010) Impact of workplace based assessment on doctors' education and performance: a systematic review. BMJ 2010, 341

O'Brien MA, Rogers S, Jamtvedt G, Oxman AD, Odgaard-Jensen J, Kristoffersen DT, Forsetlund L, Bainbridge D, Freemantle N, Davis D, Haynes RB, Harvey E (2008) Educational outreach visits: effects on professional practice and health care outcomes. The Cochrane Library, Issue 4.

Pelgrim E, Kramer A, Mokkink H, van der Vleuten C (2012) The process of feedback in workplace-based assessment: organisation, delivery, continuity. Medical Education (46).

Wallis K (2014) Regular practice review: promised joy or naught but grief and pain? Journal of Primary Healthcare (6)2.

Appendix One: Logic Model and Evaluation Framework



Logic model setting out the activities, outputs and aims of the RPR programme

Evaluation Framework

Evaluation question	Indicator	Data Source
RPR processes		
What is included in the RPR process?	• Description of RPR tools and processes	• Interviews with bpac[nz] • Review of RPR online processes
Participating doctors experiences of taking part in RPR		
How easy or difficult do doctors find completing the pre-review documents?	• Doctors understand the pre-review requirements • Doctors' opinions on obtaining multisource or patient feedback • Doctors' opinions about the ease or difficulty of preparing their e-portfolios in preparation for the review	• bpac[nz] data – numbers selecting different multi-source or patient feedback options and changes over time. • Online survey of doctors • Interviews with doctors
What do participating doctors think about the practice visit?	• Doctors report the practice visit was a positive experience • Doctor's views on working with one reviewer (compared with two reviewers for Colleges reviews) • Doctors report the practice visit provided them with opportunities to reflect on their practise -75% rate the visit as useful or very useful to them	• bpac[nz] data – numbers of visits on the planned date, changed dates (doctor or reviewer) • Online survey of doctors • Interviews with doctors
How useful did participating doctors find the RPR report?	• Doctor's assessments of the usefulness of the RPR reports - 75% rate the report as useful or very useful to them • The extent doctors consider the RPR reports reflect their own views on their practise • Doctors consider the report provides them with 'new' insights into how they could improve their practise	• Online survey of doctors • Interviews with doctors

Do doctors respond to RPR information?	• Doctors report that the RPR helps them identify areas of strengths in their practice • Doctors report that the RPR helps them identify areas for improvement • Doctors provide examples of how they have developed a PDP in response to RPR feedback • Doctor's description of changes they intend to make as a result of the RPR process and report • Doctor's description of how they will put changes into practice	• bpac^{nz} data – e-portfolio completion rates at anniversary (a potential insensitive measure) • Interviews with doctors • Online survey of doctors
Do the doctors PDP address gaps identified in the RPR report?	• Doctor's PDP respond to gaps in their learning identified by the RPR report • Doctors plan PD activities that are consistent with 'best practice' approaches to learning e.g. comparison of activities that require participation versus those requiring more than participation e.g. quizzes, log of clinical encounters • Comparison of doctors planned and actual PD activities	• Expert advisors evidence about what works • bpac^{nz} records of PDP activities for RPR doctors • Interviews with collegial relationship providers
Reviewers' experiences of RPR		
What is included in the RPR process?	• Description of the reviewer's role • Description of how reviewers were recruited	• Interviews with bpac^{nz} • Interviews with reviewers
Do reviewers consider they are adequately prepared in their role as reviewers?	• 90% of reviewers rate preparedness for the role as prepared or very prepared • 90% of reviewers rate preparedness to use the RPR tools as prepared or very prepared	• Interviews with reviewers • Online survey of reviewers

Is the workload manageable for reviewers?	• 90% of reviewers report the workload is manageable	• Online survey of reviewers
Do the reviewers consider the RPR tools provide an accurate representation of the quality of the doctors they review?	• Reviewers report the RPR tools are effective – 90% of reviewers consider the tools provide an accurate or very accurate representation of doctors they review	• Review of RPR data for completeness • Interviews with reviewers • Online survey of reviewers
Are reviewers positive about the RPR process?	• Drop-out rates of reviewers is within expected limits • 80% of reviewers rate reviewing as a positive or very positive activity • Reviewers comments about changes to their own practise as a result of their role as reviewers	• Interviews with reviewers • Online survey of reviewers
What do reviewers think about the extent RPR doctors use the RPR report to change their practise?	• The extent reviewers engage with collegial relationship providers • The extent doctors discuss PDP with the reviewers • Reviewers' opinions on the impact of RPR on facilitating changes in practise	• Reviewer interviews • Reviewer survey • Collegial relationship provider interviews
Other stakeholders' experiences of RPR		
Is the RPR process meeting the expectation of the Medical Council?	• The Medical Council considers the RPR process is developing in a satisfactory manner	• Interviews with the Medical Council
What is the role of the collegial relationship provider in assisting RPR doctors to develop PDPs in response to RPR?	• Collegial relationship providers' descriptions of their roles and perceived effectiveness • Doctor's description of how they worked with their collegial relationship providers	• Interviews with RPR doctors • Interviews with collegial relationship providers • Survey of RPR doctors

RPR achievements		
Do participating doctors assess the RPR process as useful in developing their practise?	• 80% of doctors rate their understanding of the RPR process as good or very good	• Online survey with doctors • Interviews with doctors
What changes do doctors make/ or plan to make as a result of the RPR report?	• Doctors use RPR to plan PDP and participate in planned PD activities • Doctors report changes to their practice • Tracking of any 'measurable' changes identified by individual doctors	• 12 month online survey of doctors • 12 month interviews with doctors
What aspects of the tools are effective in predicting improvements in practice?	• Variables that are aligned to practice improvement	• Analysis of RPR tool data – factor analysis and multivariate analysis with outcome of practice improvement
Are there particular groups of doctors for whom RPR is more/less effective?	• Profiles of doctors with different outcomes	• Cluster analysis of data identifies clusters of doctors with different outcomes
Does the RPR programme represent value for money for the Council?	• Establish value for money criteria with the Council in the planning year • Monitor against value for money criteria	• Interviews with the Medical Council