Malatest International

Final evaluation report

Evaluation of the Regular Practice Review Programme

August 2019

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Definitions and abbreviations

Abbreviation	Definition
bpac^{nz}	Best Practice Advocacy Centre, responsible for delivering RPR.
CME	Continuing Medical Education
CPD	Continuing Professional Development programmes
Colleague feedback	Provided on rating scales of one (poor) to five (excellent) for each of the following domains: clinical reasoning, clinical practice, communication, trust and personal aspects.
CRP	Collegial Relationship Providers
ED	Emergency Department
MCNZ	Medical Council of New Zealand (Council)
Patient feedback	Patients rating their doctors on one (poor) to five (best) scales for each of: manner, providing care, patient involvement, trust.
PDP	Professional Development Plans
RPR	Regular Practice Review
RPR ratings	Reviewers assign numerical ratings of between one and nine over thirteen categories (1-3 = unsatisfactory, 4-6 = satisfactory, 7-9 = superior). The thirteen categories are grouped into four domains.

Executive Summary

Regular practice review is a quality improvement process

In July 2013, the Medical Council introduced regular practice review (RPR) as a mandatory requirement of the recertification programme for doctors registered in a general scope of practice.

The main purpose of RPR is to help maintain and improve standards of the profession by providing a doctor with an opportunity to meet with senior colleagues to discuss the doctor's practice and think about ways it could be improved[1]. The design of RPR is based on evidence about what is effective in improving practice.

To 28 June 2019, a total of 1,183 reviews have been completed with 967 doctors: 213 doctors have been reviewed twice and three have been reviewed three times. Approximately one-half worked in community practice settings.

This report is the final report of a five-year evaluation of RPR

RPR has been evaluated since 2014. This final evaluation report focusses on the overall achievements of RPR. Previous annual reports are available on Council's website https://www.mcnz.org.nz/registration/medical-education/the-evaluation-of-rpr/.

Information for the evaluation draws on:

- Surveys:
  - Post-RPR survey: Completed by 554 doctors after their review including 447 of 775 (58%) of doctors after their first RPR and 107 of 213 (50%) doctors following their second RPR
  - Twelve-month survey: Completed by 309 doctors twelve-months after their review including 261 of 430 (61%) after their first RPR and 48 of 81 (59%) doctors after their second RPR
- Retrospective survey: A one-off final survey of all reviewed doctors at the end of the evaluation period, completed by 496 of 790 doctors (63%)
- Four surveys of reviewers (2014: 19 of 19 (100%), 2016: 22 of 30 (73%), 2017: 17 of 19 (89%), 2019: 30 of 33 (91%))
- Interviews with 130 reviewed doctors, 33 reviewers and 13 collegial relationship providers (CRP) over five years.

[1] https://www.mcnz.org.nz/registration/maintain-or-renew-registration/recertification-and-professional-development/regular-practice-review/

Regular practice review processes are well established

Pre-visit: RPR includes a review of the doctor's professional development plan in their e-Portfolio, prescribing and laboratory test reports, a phone call with their CRP and collecting multisource and/or patient feedback.

Approximately half of doctors thought collecting colleague and patient feedback was useful. Almost all patient feedback was positive and identified few opportunities to strengthen practice but provided reassurance for doctors. Colleague feedback was also generally positive but more likely to identify opportunities to improve practice.

Practice visit: A reviewer visits the doctor at their practice, interviews the doctor and in some cases colleagues, observes consultations and reviews records and clinical reasoning. The practice visit was a positive experience for 74% of doctors two-weeks after their review and 52% considered it useful in the final retrospective survey.

Post-visit: bpac^{nz} delivers a final report to the doctor summarising findings discussed at the practice visit. The review report was considered accurate by 75% of doctors two-weeks after their review and 54% of doctors in the retrospective survey reported they found it useful.

Post-visit follow-up: By bpac^{nz} with doctors for whom areas of concern or non-compliance with requirements were identified through the review.

RPR helped many doctors identify areas of strength and areas that could be improved

Half of reviewed doctors (52%) said their review identified new areas of strength in their practice and 60% said their review identified new opportunities to develop their practice.

The purpose of a professional development plan (PDP) is to describe specific learning goals that will guide the doctor's choice of continuing professional development topics and activities. In the post-RPR survey, 53% of responding doctors planned to make changes to their PDP following their review. Changes to the PDP were reported by 32% of doctors, twelve- months after their review.

Doctors were more likely to agree they would change their PDPs to target opportunities for development than to maintain areas of strength. More doctors with lower ratings said they planned to make changes to their PDP than higher rating doctors.

Many doctors act on the RPR report and make changes

After their first review, nearly half (45%) of doctors said they had made changes to their practice as a result of their review. Doctors with more lower ratings were more likely to report making changes. Many doctors said they maintained changes to their practice twelve-months after their review.

Overall, doctors working in general practice, doctors with fewer years in practice and doctors who did not speak English as a first language were more likely to have made changes to their practice following their review.

These self-reported changes alongside examples provided in surveys and interviews provide evidence that RPR is achieving its aims for many of the participating doctors.

RPR helped give assurance that competence was being maintained

On average most RPR ratings were high across all domains (records and requirements, doctor patient relationship, clinical reasoning and clinical practice). One-quarter (25%) of doctors recorded consistently 'superior' RPR ratings across all 13 RPR categories. A very small proportion had consistently low ratings across many of the 13 categories.

In the retrospective survey, three-quarters (74%) of doctors who had been reviewed were still practising under general registration. Of the remaining 26%, half (13%) had become members of a professional college.

RPR was likely to be improving the quality of care being delivered to patients

Reviewers were confident the feedback they had received from their review led to changes in practice that would improve care for patients. In response to the post-RPR survey, 43% of doctors thought participating in RPR improved the care they delivered to their patients and 52% reported it helped in other ways.

Changes in practice and professional development plans resulting in improved quality of care are likely to be improving patient outcomes, but there are no data currently available that assesses the impact of these changes on patient outcomes.

Key elements of RPR

RPR is working effectively as a quality improvement tool for most doctors being reviewed, especially the first time they are reviewed.

Effective review processes identified were:

- Understanding the purpose of the review: Clear communication of RPR as a quality improvement initiative and a collegial approach to the review.
- A well-defined review process: That left doctors feeling the reviewers had been able to get an accurate view of their practice through the information provided before the visit (the multi-source feedback) and the practice visit.
- Well trained and supported reviewers that provided the doctor with confidence they had the skills to properly understand their practice.

- Review feedback and report that reviewed doctors considered relevant and provided useful information on which they could act.

Maintaining relevance of the review is more challenging for second reviews, especially for doctors who received mainly superior ratings in their first review.

Overview

RPR is now an established programme which general registrants take part in every three to four years. RPR helps support doctors practising under a general scope of medicine to enhance their professional development and make positive changes to their practice.

RPR is viewed as useful by 52% of doctors but other doctors still view it just as an exercise they must complete to comply with their recertification requirements.

Surveys and interviews suggested the most important element of a review was that the reviewed doctors saw their review as relevant and accurate. Aspects of RPR where there is potential for improvement to enhance the extent reviewed doctors considered their review relevant and accurate are:

- Providing more clarity that the purpose of the review is quality improvement
- Considering the potential to strengthen multisource feedback by:
    - Clarifying who doctors can ask for colleague feedback.
    - Considering the time versus the benefits of patient feedback as the uniformly positive feedback did not provide an effective mechanism to identify opportunities for quality improvement.
- Reassuring doctors about their reviewer's role and expertise, especially doctors in atypical practices, who may be concerned about how RPR would work for their practice.
- Reviewing the timing of second and subsequent reviews for doctors who rated very highly or considering how to provide such doctors with useful feedback to which they can respond.

There is also the potential to further support doctors to make changes by:

- Including an additional step in the review process for reviewers to follow-up with the reviewed doctors, potentially in the form of a phone call to support practice changes and hear about the result of their work.
- Strengthening the CRP role by providing professional development about how to support their colleagues.

1. Regular Practice Review is a quality improvement programme

In July 2013, Council introduced regular practice review (RPR) as a mandatory requirement of the recertification programme for doctors registered in a general scope of practice. The primary purpose of RPR is to help maintain and improve the standards of the profession by providing a doctor with an opportunity to meet with senior colleagues to discuss the doctor's practice and think about ways it could be strengthened.

The Medical Council of New Zealand (Council) ensures that recertification programmes for all doctors are robust. This helps assure the public that doctors are competent and fit to practice and can improve the current high standards of practice of doctors in New Zealand[2].

Recertification should ensure that each doctor is supported by education that provides for their individual learning needs and is delivered by effective, efficient and reflective mechanisms that support maintenance of high standards and continuing improvement in performance[3].

In July 2013, Council introduced RPR as a mandatory requirement of the recertification programme for doctors registered in a general scope of practice. Doctors are reviewed at three-yearly intervals. The funding for RPR comes from the annual fee general registrants pay to be part of the *Inpractice* recertification programme[4].

The primary purpose of RPR is to help maintain and improve the standards of the profession. It aims to do this by helping individual doctors identify aspects of their performance that could be improved, benefiting not only their own professional development but also the quality of care their patients receive. RPR may also assist in identifying poor performance which may adversely affect patient care.

Council and bpac^{nz} developed the programme design based on evidence from academic literature[5], New Zealand experiences and discussions with stakeholders and professional organisations[6]. Council implemented RPR through the bpac^{nz} *Inpractice* programme.

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

[3] MCNZ (2016) 'Vision and Principles for Recertification'. https://www.mcnz.org.nz/assets/News-and-Publications/Vision-and-principles-for-recertification-following-the-consultation.pdf

[4] https://www.inpractice.org.nz/guides/Inpractice/IpGuide.aspx

[5] Cervero RM, Gaines JK. The impact of CME on physician performance and patient health outcomes: an updated synthesis of systematic reviews. J Contin Educ Health Prof. 2015 Spring;35(2):131-8.

[6] Lillis S (2017) 'Recertification – evidence to support change' https://www.mcnz.org.nz/assets/News-and-Publications/5cdb4f4b06/Recertification-Literature-Review-evidence-for-change.pdf

1.1 A regular practice review includes several components

- **Pre-visit**: The reviewer:
  - reviews the doctor's professional development e-Portfolio
  - reviews prescribing and laboratory test reports
  - reviews multisource feedback and/or patient feedback collected as part of *Inpractice* requirements
  - has a phone discussion with the doctor's collegial relationship provider (CRP)
  - has a phone discussion with the doctor being reviewed
- **Practice visit**: The reviewer interviews the doctor and in some cases colleagues, observes consultations, reviews records and clinical reasoning and discusses with each doctor the strengths and opportunities for improvement they observe.
- **Post-visit**: bpac^{nz} send a report to the doctor summarising findings from the review
- **Post-visit follow-up**: by bpac^{nz} with doctors where areas of concern or non-compliance with requirements were identified through the review.

Doctors participating in the *Inpractice* programme[7] must also:

- Complete a minimum of 50 hours of activity per year which must include at least:
  - 10 hours of peer review
  - 20 hours of continuing medical education (CME)
  - participation in an annual audit of medical practice.
- Develop a professional development plan (PDP).
- Complete the Essentials Quiz (a knowledge test based on Council's statements) every three years.
- Complete multisource feedback (MSF) every three years.
- Have a collegial relationship with a vocationally-registered doctor and meet the nominated colleague four times per year.

1.2 The Collegial Relationship Provider [7]

Doctors participating in *Inpractice* are required to establish and maintain a collegial relationship with a vocationally registered colleague working in the same or similar scope of practice. The CRP is expected to provide guidance and mentorship for doctors registered in a general scope. A CRP should be a role model of good medical practice, a sounding board for the doctor and a resource in times of difficulty. The collegial relationship is not a supervisory relationship.

[7] https://www.inpractice.org.nz/guide/IpGuide.aspx

Doctors are required to meet with their CRP:

- Six times in the first twelve-months of registration in general scope.
- Four times per annum in subsequent years.

Meetings may be face-to-face or remote (e.g. teleconference, Skype). The key requirement is that they are simultaneously interactive: for example, email exchanges do not meet the requirements.

2. The five-year evaluation of Regular Practice Review

RPR has been evaluated since 2014. This is the final evaluation report. Previous annual reports are available on Council's website.

Council commissioned a five-year 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 professional development.
- 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 for patients.

The focus of the evaluation therefore was on what is being achieved by RPR. Responsibility for monitoring the effectiveness of the implementation sat with the service provider, bpac^{nz}.

This is the final RPR evaluation report. Previous annual reports can be found on Council's website. https://www.mcnz.org.nz/registration/medical-education/the-evaluation-of-rpr/

2.1 The evaluation was based on a logic model and evaluation framework

The RPR evaluation was based on a logic model (Appendix 1) and evaluation framework (Appendix 2) that set out the evaluation questions, the indicators and information sources. The evaluation framework was agreed with Council and provided the basis for the development of surveys and interview guides.

Information for the evaluation has been drawn from:

- Information collected by bpac^{nz} as part of administrating RPR.
- Online surveys sent to all reviewed doctors approximately two-weeks after they received their RPR report and twelve months later.
- A final survey sent to all reviewed doctors in April 2019.
- Interviews with a sample of doctors who complete the surveys[8] and their CRP.
- Online surveys and interviews with reviewers in 2014, 2016, 2017 and 2019.

[8] As this report builds on earlier evaluation reports, some of the quotes used are the same as those used in previous reports.

Figure 1 provides a summary of the numbers completing the survey and interviews to the end of the evaluation (June 28, 2019).[9]

Data source	First RPR 967 reviews	Second RPR 213 reviews	Reviewers
Online surveys	• Post-RPR survey of doctors (447 of 775, 58%) • Twelve-months after RPR (261 of 430, 61%)	• Post-RPR survey of doctors (107 of 213, 50%) • Twelve-months after RPR (48 of 81, 59%)	• 2014 (19 of 19, 100%) • 2016 (22 of 30, 73%) • 2017 (17 of 19, 89%) • 2019 (30 of 33, 91%)
	• Retrospective survey - Completions (496 of 790, 63%) • First RPR (339, 68%), Second or more RPRs (157, 32%)		
Interviews	• Post-RPR interviews with doctors (87) • Interviews approximately 12 months after first RPR (32)	• Post-RPR interviews with doctors (11)	• 2014 interviews (6) • 2016 interviews (9) • 2017 interviews (5) • 2019 interviews (13)
Other sources of data			
bpac^{nz} data	• Patient feedback forms completed before the RPR visit (25,062) • Colleague feedback for participating doctors completed before the RPR visit (8,340) • RPR report results for all participating doctors (1st RPR 967, 2nd RPR 213, 3rd RPR 3, total RPR reports 1,183)		
Other	• A review of the literature about professional development		
	• Interviews with collegial relationship providers (13)		

Figure 1. Information sources for the evaluation to June 28 2019.

An overview of the strengths and limitations of the evaluation is provided in Appendix 3.

[9] The total number of doctors invited to take part in the evaluation is less than the total number of doctors reviewed because the evaluation started after the introduction of RPR. The first 192 doctors who were reviewed were not included in the evaluation. By the end of the evaluation not all doctors were eligible for the twelve-month data collection.

3. Doctors who have been reviewed

A total of 1,183 reviews have been completed with 967 doctors. Approximately half worked in community practice settings.

Up to 28 June 2019, there have been 1,183 reviews including 967 first reviews, 213 second reviews and three third reviews. The first years of RPR focussed on doctors working in general practice settings which is why they represent most (85%) of the second reviews. First reviews now include approximately the same numbers of doctors in general practice as other settings.

Table 1. Number of RPRs

	Worked in general practice	Did not work in general practice	All doctors
First Review	467 (48%)	500 (52%)	967 (100%)
Second review	181 (85%)	32 (15%)	213 (100%)
Third review	2 (66%)	1 (33%)	3 (100%)

The characteristics of doctors reviewed are summarised in Table 2. The only substantial difference in the demographic profiles of doctors reviewed for the first and second times was a higher proportion of doctors who had been in practice for more than 10 years. This difference is consistent with the second review taking place three years after the first.

Table 2. Doctors working in general practice vs doctors not working in general practice (Post RPR survey – first and second RPR)

	Worked in general practice	Did not work in general practice	All doctors
First review	**n = 206**	**n = 241**	**n = 447**
New Zealand trained	34%	43%	39%
Years in practice in NZ			
≤10 years	60%	44%	52%
11-30 years	32%	44%	38%
30+ years	8%	13%	10%
English was the first language	77%	73%	74%
Second review	**n = 94**	**n = 13**	**n = 107**
Trained in NZ	28%	69%	33%
Years in practice in NZ			
≤10 years	23%	15%	22%
11-30 years	59%	54%	59%
30+ years	18%	31%	20%
English was the first language	73%	92%	76%

4. Regular Practice Review processes are well established

Approximately half of doctors thought colleague and patient feedback was useful. Almost all patient feedback was positive and identified few opportunities to strengthen practice, but the positive feedback provided reassurance for doctors. Colleague feedback was also generally positive but more likely to identify opportunities to improve practice. The practice visit and review report were the most important elements of a review and considered useful by 52% and 54% of doctors.

4.1 Pre-visit

In response to the 2019 retrospective survey of all doctors reviewed, 49% said patient feedback was useful and 55% said colleague feedback was useful[10] (Figure 2).

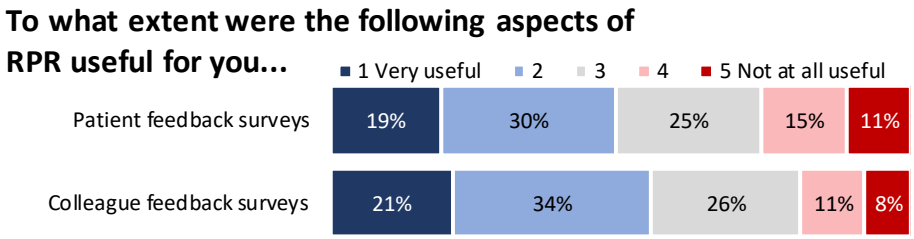

Figure 2. Doctors' views on patient and colleague feedback (Retrospective RPR survey, n = 496) (Patient feedback N/A n = 36, Colleague feedback N/A n = 16).

4.1.1. Patient feedback

Patient feedback was based on scales from one (least positive) to five (most positive) where patients could rate their doctor over four areas of practice (Table 3). Almost all patient feedback was positive and identified few examples of how doctors could strengthen their practice.

Table 3. Average percentage of doctors in each patient feedback rating category (1 = worst, 5 = most positive) (Includes first and second RPRs)

Domains assessed	1-3	3.01-4	4.01-4.5	4.51-5
Manner (n = 633)	0%	0.6%	5.1%	94.3%
Providing care (n = 633)	0%	0.8%	5.7%	93.5%
Patient involvement (n = 632)	0%	1.4%	8.7%	89.9%
Trust (n = 633)	0%	0.6%	7.6%	91.8%
Total mean score	**0%**	**0.3%**	**6.6%**	**93%**

[10] Rated as 1 or 2 on a 5 point scale

Some doctors found positive patient feedback reassuring. Others noted that doctors could choose who filled in their feedback forms so could 'cherry pick' people they thought would rate them positively.

> *I was reassured to know that patients felt I was doing a good job as that is ultimately the best benchmark to my performance. (First RPR)*
>
> *The patient and collegial feedback are not that useful, the latter being a group of self-selected referees answering a fixed set of written questions and the former collected from loyal patients on a day when I tried harder to be nice. (First RPR)*

Obtaining patient feedback could be difficult for doctors in some workplace settings. For example, in palliative care or where doctors worked with patients with mental health issues or dementia who were not aware of their surroundings. Doctors who only saw a patient once, such as in emergency care, travel medicine and health screening settings, often discussed how their ratings were not comparable to doctors working in practice settings where they could build an ongoing relationship with patients.

4.1.2. Colleague feedback

Colleague feedback used the same one-to-five scale as patient feedback. Almost all colleague feedback gave doctors ratings between four and five. The largest proportion of high scores (95.4%) was in the 'trust' domain and the lowest proportion (69.7%) was in the 'communication' domain (Table 4).

Table 4. Average percentage of doctors in each colleague feedback rating category (1 = worst, 5 = best) (n = 778[11])

Domains assessed	1 - 3	3.01 - 4	4.01 - 4.5	4.51 - 5
Clinical reasoning	0	3.2%	23.9%	72.9%
Clinical practice	0	2.3%	24.3%	73.4%
Communication	0	4.1%	26.2%	69.7%
Trust	0	0.1%	4.5%	95.4%
Personal	0	1.7%	13.9%	84.4%
Total mean score	**0**	**0.6%**	**16.2%**	**83.2%**

Some doctors described not being sure who they could or should ask to provide colleague feedback:

- Locum doctors often described getting colleague feedback as challenging as they did not work in one location for long and had not built up working relationships.
- Some doctors working in specialist areas of medicine (especially outside of the larger New Zealand cities) said they only interacted with a few health professionals and often only through referral letters.

[11] Includes data provided by bpac^{nz} from all first and second reviews.

Such issues may reflect a wider problem of lack of professional contact. However, at a practical level it may be worth considering adding to the instructions about *'who should fill these in'* to provide clearer guidance for reviewed doctors or perhaps adding a section of commonly asked questions about completing patient and colleague feedback.

4.2 The practice visit

The practice visit is a key part of RPR. It is the part of the process with the highest cost and the greatest potential benefit.

> *[The visit is important because] it is different when people fill [out] a form on paper, their perception of what they do and the reality of what happens, so I watch them interacting with the patients, I see them interacting with the other nurses, and although they're trying to be on their best behaviour on the day, from experience you can sense the areas that they're either not very good at or the shortcuts that they take. (Reviewer)*

Almost all reviewers were positive about the practice visit and the opportunity the practice visits provided for face-to-face discussions with the doctors (Figure 3).

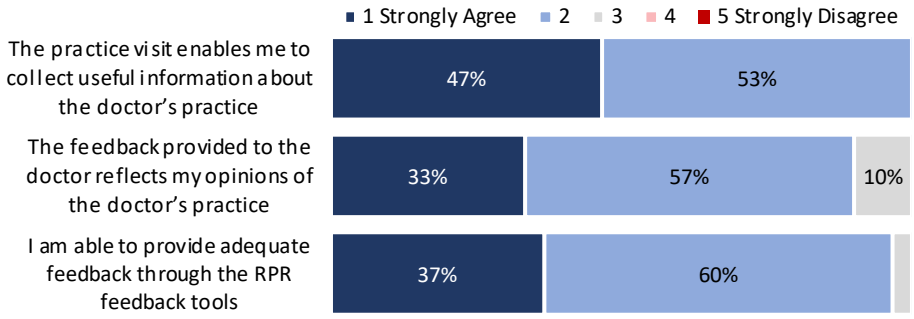

Figure 3. Reviewers' views on the practice visit and feedback to the reviewed doctors (2019 reviewer survey, n = 30).

Discussions before and at the beginning of the practice visit were used to put the doctors at ease and reassure them about the purpose of RPR. Reviewers often explained RPR was not an audit of their fitness to practice but instead a chance to be supported.

> *[I tell them] the [reviewer] role is to ensure that the doctor being reviewed is practising in an environment that supports him or her to provide safe care, to ensure that the environment acknowledges their – that's the reviewee's – training needs, and other professional needs I should say – things like leave, and study time, and most interestingly from my point of view, to identify strengths and weaknesses in the reviewee's practice and perhaps suggest some ways forward to try and improve performance. (Reviewer)*

The debrief sessions at the end of the visit were used to reiterate the main points the reviewer raised throughout the day. Reviewers saw it as a chance to leave a positive message with the doctor and to make sure there would be no surprises in their RPR report.

> *I think the debrief is really important. I think it's essential. I think it's important that what's said in the debrief is reflected carefully in the report, particularly those areas where I think*

I've identified that need more work, because it's important that the report doesn't come as a surprise. (Reviewer)

RPR reviewers reported they were positively received by doctors. Most agreed doctors were receptive to the practice visit and the reviewer's feedback (Figure 4).

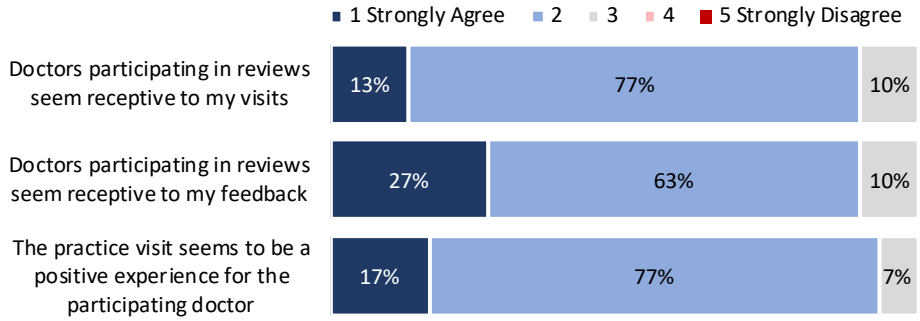

Figure 4. Reviewers' views on doctors' reactions to RPR (2019 reviewer survey, n = 30).

Aspects of the practice visit which influenced doctors' experiences included how easy the visit was to organise, the availability of patients, how well RPR fitted into their practice, whether they considered the day of the practice visit was representative of their practice and their opinion of the reviewer.

In the post-review survey, doctors were generally positive about their experience of the practice visit with only a very small proportion disagreeing (Figure 5). Most doctors considered the practice visit was long enough to provide the reviewer with an accurate view of their practice. Three-quarters also agreed the practice visit caused them to reflect on their practice.

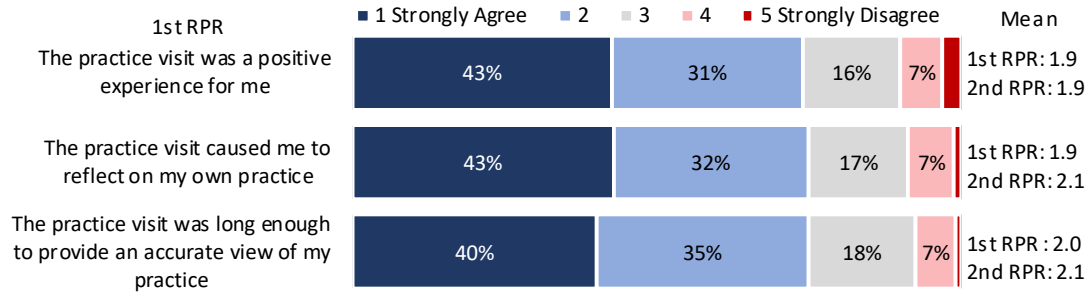

Figure 5. Doctors' views on their experience of the RPR practice visit, limited to those having their first RPR (Post-RPR survey, first RPR only n = 446).

In the 2019 retrospective survey of all reviewed doctors, more than half considered the practice visit had been very useful (23%) or useful (29%) for them (Figure 6). The 27% who did not find it useful often felt this way because they considered they were already well supported and/or kept themselves up to date.

I found the direct contact with a genuine, though objective peer of massively greater value than any number of patient and other time consuming, meaningless surveys - which ongoing CME demands. In my view clinical CME meetings and thorough peer review ought to be the real and probably only lynchpins of doctors' CME. (Retrospective survey)

I work as a SMO in a hospital setting. We have multiple meetings and educational opportunities. We work in a team and constantly ask each other second opinions. I feel well supported and safe in my practice. Inpractice is a very nicely set out computer programme - but I don't feel it is helpful for me or my patients. (Retrospective survey)

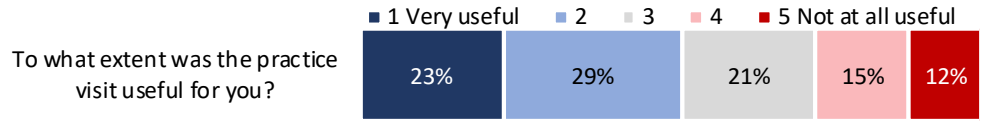

Figure 6. Usefulness of practice visit (Retrospective RPR survey, n = 494, 2 N/As removed).

Doctors working in team-based settings, such as hospitals, were less likely to see the need for RPR than those working in more isolated situations. They often believed they already took part in similar activities or worked closely enough with other professionals that any concerns would become apparent.

Hospital based ED workers [like me] are constantly in collaboration with consultants daily and structured teaching programs throughout the year. (Retrospective survey)

Reviewers enjoyed getting to see their peers' practice which gave them ideas about how they could improve their own practice.

This [being a reviewer] is the best thing I have done for my own practice development in the last ten years (i.e. since gaining my College Fellowship). I would like these to be implemented across vocational registrants as well. (Reviewer)

Reviewing doctors in other areas of practice was a good way for reviewers to expand their knowledge (Figure 7). However, many reviewers we interviewed felt less confident reviewing doctors in different areas of medicine to their own.

'Scope' as defined by the Medical Council is different from accredited scope of practice. As an [particular] specialist, it is sometime difficult for me to assess those in sub-specialties very different from my own. (Reviewer)

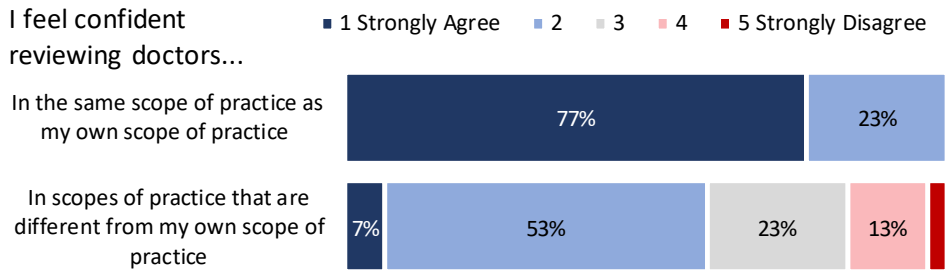

Figure 7. Reviewers' confidence in reviewing different scopes of practice (2019 reviewer survey, n = 30).

The RPR process has been adapted for some medical branches outside general practice. Where it has not been adapted there is flexibility for the reviewer to tailor the review process to the setting. Some doctors appreciated this level of flexibility, but others thought it did not go far enough.

Case study example of a positive review experience: First review

Dr A completed his medical training in New Zealand 30 years ago and worked in a small niche area of medicine. Before his review, Dr A had a very poor impression of RPR and thought it would be a "*tick box"* exercise of little to no value. He expected *"a bit of a grilling"* and to hear he was good for another three years.

Once the visit was complete Dr A said that rather than getting a *"grilling"* he found the review was constructive. He described the reviewer as *"collegial but necessarily formal"*. He found the reviewer good because he was of a similar age and had a lot of experience in the medical area in which Dr A worked. Dr A talked about matching reviewers with doctors being of the *"utmost importance"*.

During the visit and in the RPR report the reviewer suggested changes Dr A could make to improve his practice. These included suggestions on practical case administration, insights into his practice as well as discussions on CME.

Following the review, Dr A said he had made changes to the way he works, *"not big things but little improvements that would improve his practice"*. He created one specific goal to address an opportunity highlighted in his RPR feedback. At the conclusion of the process Dr A felt the review was *"very fair, accurate and a really worthwhile exercise".*

Case study example of a negative review experience: First review

Dr B had over 30 years of experience and was vocationally registered overseas, although his vocational training was not recognised in New Zealand.

Dr B did not expect to get anything out of RPR and therefore had a somewhat negative attitude. He felt, both before and after his review, that he was a senior doctor with a good record and should not need to be checked. He also considered that his collaborative practice environment meant any concerns about competency would be identified.

Dr B found RPR resource intensive and organising and participating in it somewhat *"anxiety inducing"*. He felt embarrassed asking patients to fill in the feedback forms and that collegial feedback would not yield anything that would not come up anyway.

Dr B considered the reviewer his junior and not experienced in his speciality. He thought the RPR questions were not well suited to his area of practice.

Although Dr B found the practice visit unhelpful, he commented that the reviewer did as good a job as possible and the experience was pleasant and collegial.

Dr B reported not receiving any suggestions about ways to improve. He said that while it was nice to have your practice affirmed with positive feedback, he was already aware of everything raised. There were no new goals created in his e-portfolio following his review.

4.3 RPR reports

During the practice visit reviewers discuss their feedback, including strengths and opportunities for development and links to PDP goals, with the reviewed doctors. RPR reports are the formal mechanism for providing feedback and are sent to the reviewed doctors after the practice visit. Reviewers aim to ensure all points for development are discussed with the doctor during the practice visit so the subsequent report does not contain any surprises.

All the interviewed reviewers thought the latest report template allowed them to say what they needed.

All reviewers thought the report was a good idea but saw the face-to-face discussions with doctors as the most important part of the review. The report served as a record of the visit that doctors could reflect on after the event as well as a being a tangible record of their competence.

> *I think the report usually helps them because it's got some status. Whether we think a report should have more status than just a korero with somebody is debatable but then they get the report and it gives them a moment of pause. (Reviewer)*

4.3.1. RPR ratings

Reviewers assign numerical ratings of between one and nine over thirteen categories (1-3 = unsatisfactory, 4-6 = satisfactory, 7-9 = superior) grouped into four domains (Table 5).

Table 5. Review categories assessed by reviewers

Review domains	Review categories
Records/requirements	Ability to competently navigate and use PMS Notes facilitate continuity of care Records show appropriate standard of care Record is clear, accurate, has required information
Doctor/patient relationship	Engaging the patient Responding to the patient Listening to patient
Clinical practice	Clinical practice management Clinical practice history Clinical practice examination
Clinical reasoning	Clinical reasoning for their management Clinical reasoning for investigation Clinical reasoning for diagnosis

In the 2019 retrospective survey of all reviewed doctors, more than half said they found the review report very useful (23%) or useful (31%). A higher proportion said they found the report useful in response to the survey they completed shortly after their review.

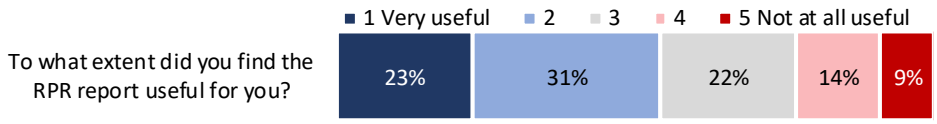

Figure 8. Usefulness of RPR report (Retrospective RPR survey, n = 490, 6 N/As removed).

Three-quarters (75%) of doctors agreed their RPR report accurately described their practice (Figure 9).

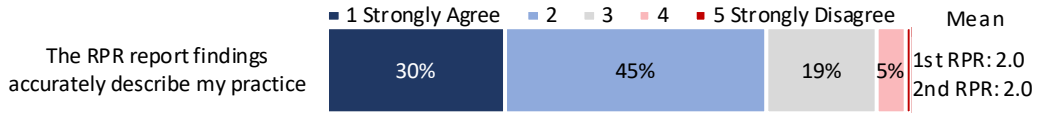

Figure 9. The percentage of doctors who agreed the review reports accurately described their practice (Post-RPR survey, first RPR n = 446, second RPR n = 107)

Doctors who received more lower RPR ratings (ratings less than 7) were significantly ($p < 0.05$) less likely to agree their report findings were accurate (Figure 10).

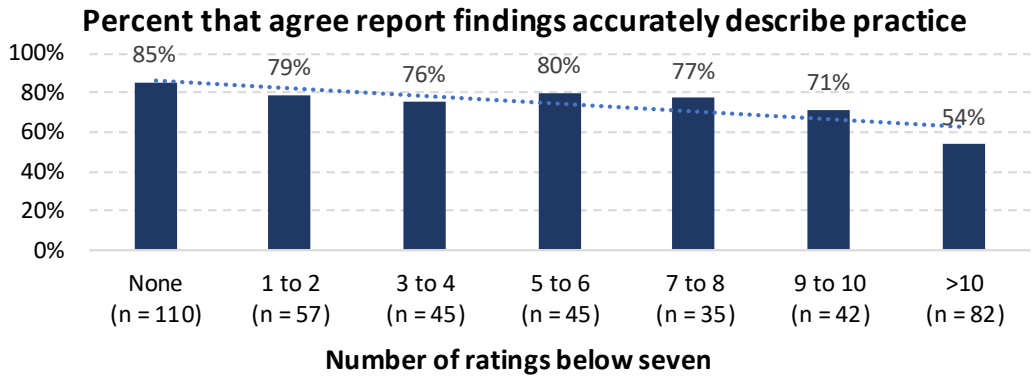

Figure 10. Percent of participants who agreed their RPR report accurately described their practice by the number of RPR ratings below superior (1-6 out of 9 over 13 RPR categories, first RPR)[12].

4.4 Post-visit follow-up

The extent of follow-up after the written RPR report depends on the individual doctor. If there are any concerns or non-compliance issues arising from the review, bpac[nz] follows-up with the doctor. Other doctors do not generally receive further feedback or follow-up until their next RPR three years later.

[12] Reviewers assign numerical ratings of between one and nine over thirteen categories (1-3 = unsatisfactory, 4-6 = satisfactory, 7-9 = superior).

4.5 The Collegial Relationship Provider[13]

After their review, doctors are encouraged to speak with their CRP about their review report findings and to plan how best to utilise the feedback. Two-thirds (66%) of doctors reviewed for the first time said they did so (Figure 11). The proportion was similar for doctors after their second review (67%). During the reviewer's preliminary conversation with their CRP it may be helpful to make a point of suggesting the CRP proactively ask reviewed doctors about their RPR report and suggest they discuss it at their next meeting.

As expected under the *Inpractice* collegial relationship requirements, the CRP relationships involved a combination of informal discussion of cases (by phone, email or in-person) and formal and regular meetings.

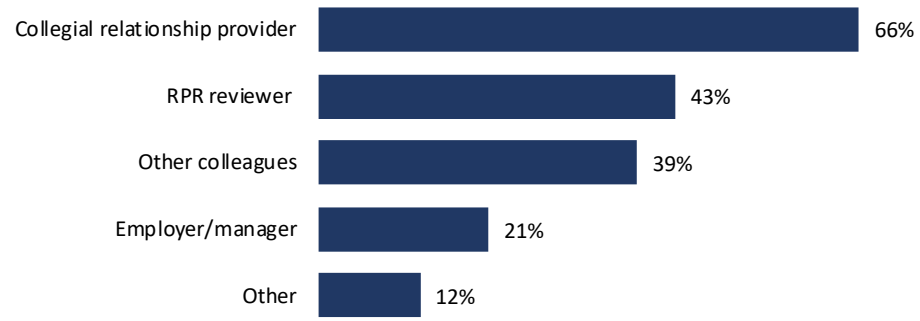

Figure 11. Who doctors discussed their PDP with (Post-RPR survey first RPR only n = 446).

Doctors who received more RPR ratings below seven appeared to be slightly more likely to discuss their PDP with someone.

Table 6. Who doctors discussed their PDP with by number of ratings below seven (Post-RPR survey, first RPR, excluding doctors who responded N/A, or who did not receive RPR ratings[14])

Person PDP discussed with	Likelihood of discussing findings		
	0 to 2 ratings below 7 (n = 153)	3 to 6 ratings below 7 (n = 84)	7 or more ratings below 7 (n = 138)
Collegial relationship provider	60%	67%	72%
RPR reviewer	40%	46%	48%
Other colleague	29%	40%	47%
Employer/manager	13%	22%	28%
Other	11%	11%	15%

[13] https://www.mcnz.org.nz/registration/maintain-or-renew-registration/recertification-and-professional-development/collegial-relationships/

[14] Not all doctors receive RPR ratings as it is not appropriate for the type of work some do e.g. administrative work

5. RPR helps many doctors identify areas of strength and areas of their practice that could be improved

Half of reviewed doctors (52%) said their review identified new areas of strength in their practice and 60% said their review identified new opportunities to develop their practice.

The purpose of a professional development plan (PDP) is to describe specific learning goals that will guide the doctor's choice of continuing professional development topics and activities. In the post-RPR survey, 53% of responding doctors planned to make changes to their PDP following their review. Changes to PDP were reported by 32% of doctors, twelve- months after their review.

Doctors were more likely to agree they would change their PDPs to target opportunities for development than to maintain areas of strength. More doctors with lower ratings said they planned to make changes to their PDP than higher rating doctors.

5.1 The reviews helped many doctors identify their strengths and new areas for development

Many doctors were already aware of the areas of strengths and development identified in their review reports (Figure 12). Approximately half (52%) of doctors responding to the survey agreed that new areas of strengths were identified in their first review and slightly fewer (47%) in their second review.

Sixty percent of doctors agreed their first review report identified new opportunities to develop their practice with a smaller proportion (51%) agreeing their second review identified new opportunities to develop their practice.

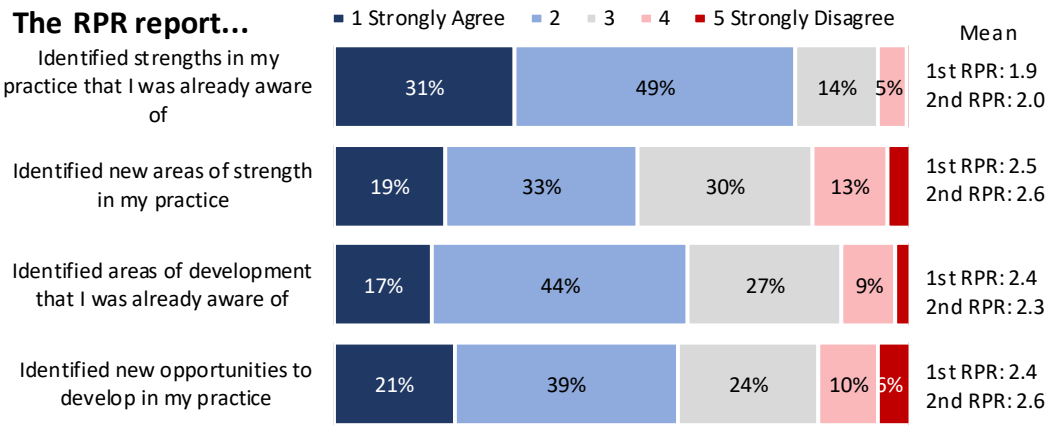

Figure 12. The extent doctors considered RPR helped them identify strengths and opportunities for development (Post-RPR survey, first RPR n = 446)

5.2 Reviewers discussed professional development plans (PDPs) with doctors

The purpose of a professional development plan (PDP) is to describe specific learning goals that will guide the doctor's choice of continuing professional development topics and activities[15]. Reviewers said they discussed PDPs with the doctors they reviewed. While reviewers were generally confident the feedback they gave would result in changes, they did not have the opportunity to see any changes.

> *I really have a major concentration on [PDP] at the end of our interview, and I'll buy them a coffee and sit there and really try to figure out first, you know, "What do you want out of your life?" (Reviewer)*

Some reviewers thought more experienced doctors might be less likely to change their PDPs because:

- They were more likely to be practising at a high level and did not need to make major changes.
- They were more set in their ways and confident in their practice.

Case study example: Rethinking PDP

Before his review, Dr C felt PDP requirements were not worthwhile and caused considerable annoyance and stress. After the reviewer explained what the requirements for him were and how they could be relevant, Dr C's outlook on PDP changed.

> *I have started filling it out. I didn't realise just how much of my daily activity would be considered CME…. So, the result is that I am thinking about it more and thinking what I'll write down and what I'll get out of the things I do…. Before the RPR I thought of the entire thing as an absolute pain in the arse and worth nothing.*

5.3 Doctors planned to make changes to their PDP

In the post-RPR survey, half (53%) of doctors planned to make changes to their PDP following their review (Figure 13). Doctors were more likely to agree they would change their PDPs to target opportunities for development than to maintain areas of strength.

> *Yes, it was helpful because it enabled me to look at my PDP and maybe make objectives, smarter. And it gave me something that I could aim for, for the future, with what I intended to do... It more specifically, the one that we particularly brought out was medical record-taking and how to perhaps improve that and put it towards doing a fellowship of the New Zealand College of GPs. (First RPR)*

[15] https://www.inpractice.org.nz/guides/Inpractice/IpGuide.aspx

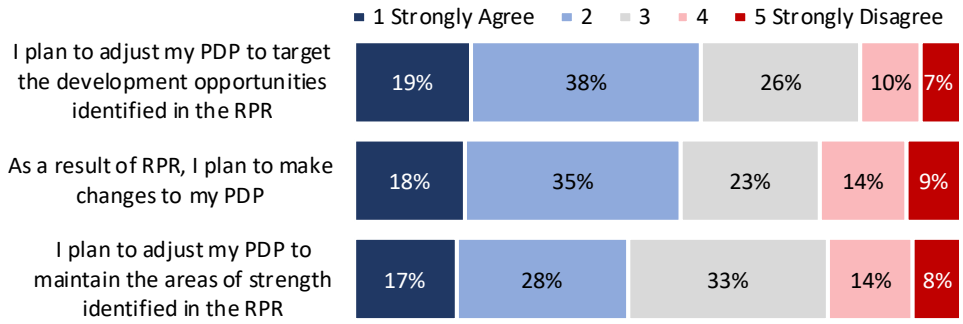

Figure 13. Doctors' changes to their professional development plans (Post-RPR survey, first RPRs, n = 446).

Most doctors who did not plan on making changes to their PDP said this was because they did not receive any feedback they could action. A few disagreed with the RPR findings.

> *[Did you make changes to your PDP?] I suppose yes and no. Yes, in the sense that there were suggestions made regarding the requirements for Bpac and how I do that, but not to actually change what I am doing for professional development. (First RPR)*

There was a significant ($p < 0.05$) increasing trend for doctors with more low RPR ratings (under 7) than higher rating doctors who indicated they had made changes to their PDP (Figure 14).

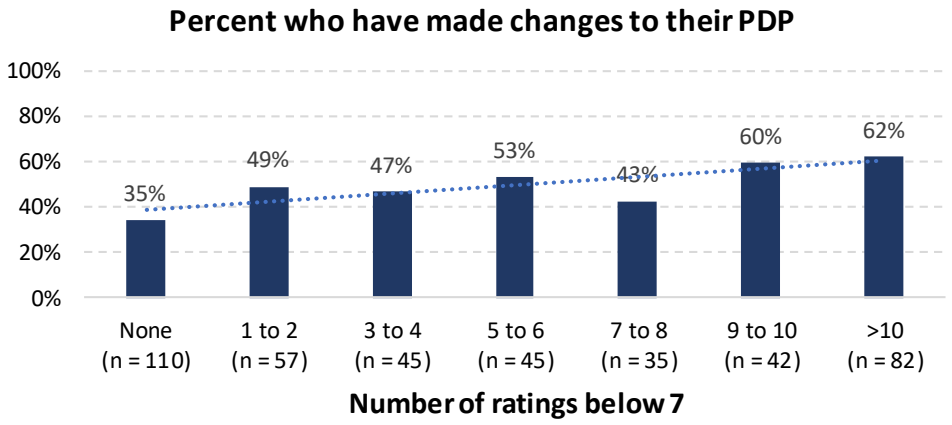

Figure 14. Percent of participants who reported learning new opportunities for development by the number of RPR ratings below superior (1-6 out of 9 over 13 RPR categories, first RPR).

Making changes to practice requires doctors to understand the steps required to respond to development opportunities. Almost all (87%) doctors whose reports identified new opportunities for development agreed the actions needed to address the new development opportunities were clear.

Some doctors wanted more guidance on how they could improve their practice. In interviews, even doctors who received very positive ratings wanted to receive some practical advice.

To some extent she was pointing out things that I maybe hadn't thought of, so she outlined some things I was aware of and others that I wasn't so much. (First RPR)

Where relationships were strong, CRPs appeared to be of substantial value in supporting doctors' professional development, and the CRPs felt that they were contributing to improvements in the doctors' practice. In other cases, the CRP relationships were primarily informal and at times included barriers to open and honest communication (for example, where the CRP provider was the doctor's employer).

Providing feedback and support that can lead to practice improvement is a skilled process and not all CRPs may have the appropriate motivation, skills or experience for the role. Although there is a comprehensive guide for CRPs on the *Inpractice* website it may not be well utilised.

As a result of this feedback MCNZ completed a review of collegial relationships and developed further guidance on the role of the CRP and tools to assist in discussing feedback and using it to inform a doctor's PDP.

5.4 Some doctors documented changes to their PDP goals

Doctors use their e-Portfolio to keep their PDP up to date. Doctors are asked to create goals and report how they identified the need for the goal.

There is wide variation in how doctors manage their PDP goals. It is difficult to analyse PDP goals because records are 'overwritten' when they are updated, which is required at least twelve-monthly. However, in some cases, doctors specifically identified RPR as the reason they made a PDP goal in the bpac^{nz} online system. Some examples are shown in Table 7.

Table 7. Description of goals and how the need was identified (bpac^{nz} goals data, all examples of from doctors first RPR)

Description of goals	How the need for the goal was identified
Good medical record keeping	*RPR*
When to treat with antibiotics	*Discussion with RPR assessor*
How to best look after my personal mental and physical health in order to work and live to my full potential	*At my RPR visit this was one of the topics that was recommended that I look into in order to maintain my own mental well being*
Ways of understanding and providing increasing input into curriculum development and teaching strategies.	*Discussion with colleagues and RPR reviewer*

I plan to further improve my medical practice and enhance communication with patients, improve patient care, and record keeping	*Some of the recommendations made verbally at RPR review i.e. more consistently provide a summary of my conclusions to patients, improve time management, try to avoid a delay in writing patient notes* *Having been made aware of these issues I have been actively incorporating the above RPR recommendations in my practice from today.*

Case study: First review

Having graduated around five years ago, Dr D still considered himself a junior doctor and was keen to have some collegial support from the reviewer. He had worked in urgent care medicine but was working in general practice at the time of his review.

Dr D appreciated having a senior doctor sit in with him to highlight the strengths and weakness of his practice. The reviewer provided helpful advice and suggestions on Dr D's consultation style, record keeping and his approach to PDP.

Dr D also discussed how RPR helped him understand and implement his PDP more effectively. Dr D went on to create two e-portfolio goals directly after RPR to address the feedback he received from the review.

> *I have started auditing my clinical notes and history taking and I am doing much better with that now. The RPR was really helpful in steering me how to implement my PDP. Initially I was quite unclear how to do it. But following my RPR it was much clearer.*

Dr D also reported making significant changes to his practice because of the reviewer's feedback. The changes included being more patient-centred, taking more care to delve further into a patient's history as well as improving note taking.

> *I brought that mind set of patching people up and sending them away…. So since the RPR session I am reminded of how it can be helpful in certain situations to delve a bit more into patient history and ask a bit more and spend a bit more time with the patients to help provide care for my patients. So it has helped immensely in that way.*
>
> *Also in recording of notes…. It's quite easy to get carried away [doing short notes], especially when reading notes of other GPs. Some of them are very, very brief and quite inadequate but I had learnt to adopt what they were doing. So, the RPR was quite a helpful experience to steer me back towards making sure my notes hold up.*

5.5 Examples of changes to professional development

Although it was hard to identify professional development goals doctors entered following their review, many doctors who responded to the survey said they had made changes to their PDP across all areas of practice. Examples of changes doctors made to their PDPs and ranged from management of their portfolios to specific development activities.

Table 8. Examples of changes to professional development

Change to PDP	Example
Improving professional development management	*To document the PDP plan a bit more clearly although in reality I would be doing the same things but it would look more professional on paper. (First RPR)*
Improving the quality of PDP and goals	*[I now] set small realistic achievable goals - they do not have to be long laborious processes- e.g. read up on a topic that baffled you that day then tick the box. (First RPR)* *What has changed in terms of the goals is that he suggested that I should focus on more short-term goals, so… Rather than say for example, improving my clinical ability in dermatology and skin diseases, he said, "Make it a lot shorter and more defined," like it might be, diagnosing a particular type of skin cancer. (Second RPR)*
Improving attitude towards PDP	*This programme has widened my thought process on formal CME and professional development and delivered a useful level of benchmarking. (First RPR)*
Literature and evidence reviews	*It pulled out one area of minor weakness of needing to follow-up on best practice guidelines and I agree with that advice and will be doing that. (First RPR)* *Some of the basic background knowledge is a bit rusty. I'll just hit the books a bit more and keep abreast of the journals. (First RPR)*
Participating in more meetings/peer review groups	*I've also signed up for the monthly post-grad meetings that the GPs and public health doctor meetings that people here have in [town]. (First RPR)*
Completion of more PDP	*Just attended a conference and completed outstanding tasks for this year. (First RPR)*
Further training	*[I] will apply for GP training this year. (First RPR)*
Self-audit activities	*RPR has identified that my use of laboratory investigations was higher than that of most other GPs. This had made me develop the plan to conduct an audit. (First RPR)*

5.6 Some doctors continued to describe changes to their PDP twelve-months after their review

Twelve-months after their review, 32% of doctors reported making changes to their PDP, 21% of doctors reported they had changed how they managed their PDP and 23% had changed their PDP to make it more useful (Figure 15).

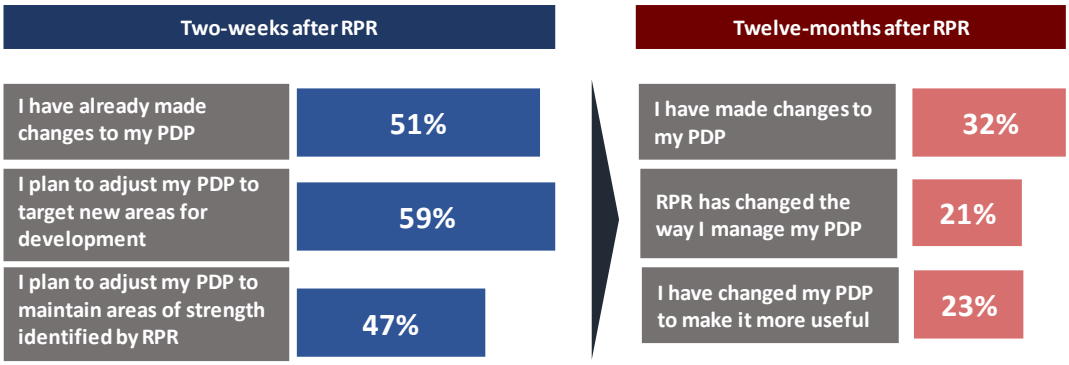

Figure 15. Doctors reporting changes to their professional development plans two weeks and 12-months after RPR (post-RPR and 12-month surveys, first RPR only n = 261).

6. Many doctors act on their RPR report and make changes

After their first review, nearly half (45%) of doctors said they had made changes to their practice as a result of their review. Doctors with more lower ratings were more likely to report making changes. Many doctors said they maintained changes to their practice twelve-months after their review.

Overall, doctors working in general practice, doctors with fewer years in practice and doctors who did not speak English as a first language were more likely to have made changes to their practice following their review.

These self-reported changes alongside examples provided in surveys and interviews provide evidence that RPR is achieving its aims for many of the participating doctors.

6.1 Most reviewers thought doctors would make changes

Most reviewers thought RPR would enable doctors to make changes to their practice (Figure 16).

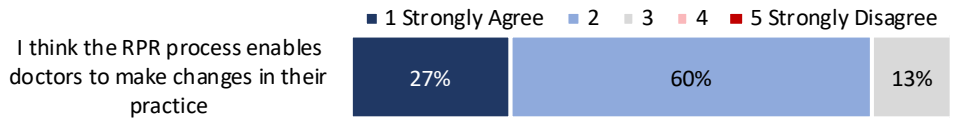

Figure 16. Reviewers' views on whether RPR contributed to changes in practice (2019 reviewer survey, n = 30).

6.2 Doctors reported acting on their review findings and making changes to their practice

An analysis of systematic reviews[16] found changing practice through review and professional development was possible. In the post-RPR survey, nearly half (45%) of the responding doctors said they had already made changes to their practice because of their review, and a further 17% intended to make changes.

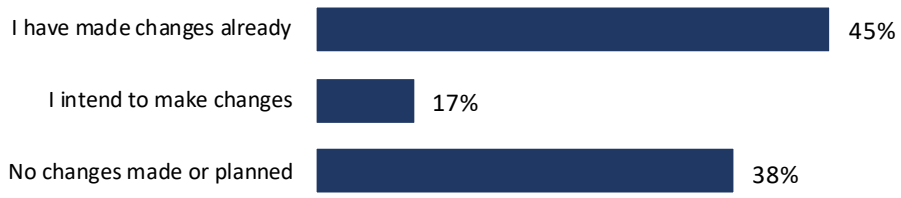

Figure 17. Proportion of participating doctors who said they had made changes, intended or did not intend to make changes (Post-RPR survey, first RPR n = 446).

[16] Bloom, B. S. (2005). Effects of continuing medical education on improving physician clinical care and patient health: A review of systematic reviews. International Journal of Technology Assessment in Health Care J. of Inter. Tech. of Health Care, 21(03), 380-385.

Doctors who reported changes included those with mainly superior ratings (no RPR ratings below 7) as well as those with lower ratings (Figure 18). Those with more lower ratings (57%) were significantly more likely to report making changes ($p < 0.05$) than doctors with no ratings below seven (37%).

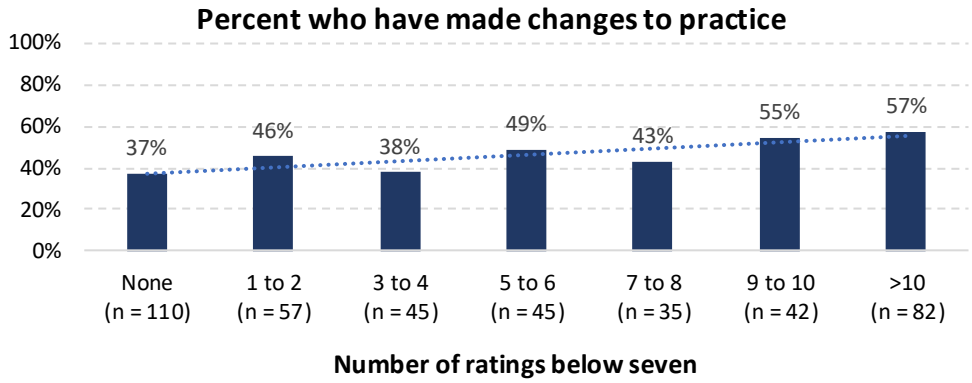

Figure 18. Percent of participants who have made changes to their practice by the number of RPR ratings below superior (1-6 out of 9 over 13 RPR categories, first PRR).

The changes doctors said they made to their practice included changes to consultation management and style, patient care and administration (Table 9). The percentages in the table represent doctors who volunteered this information in response to an open-ended question about changes they had made. The distribution of changes made is similar for first and second reviews.

Table 9. Changes participating doctors have made following their review (Post-RPR survey n = 446, first RPR)

Area of change			Example
Consultation	Changed how consult is managed	10%	*Tried to change consultation style, trying to prioritise patient questions.*
	Communicating more effectively	10%	*Changed how I word questions to patients. Better use of silence.*
Patient care	Improved notes and record keeping	12%	*Consult notes are completely different and try to reflect content of consult and more accurately report findings as well as future intentions for better follow-up by colleagues.*
	Reviewed prescribing	5%	*[I] have made changes to my prescribing methods and there is a new awareness of having to constantly check current guidelines.*
	Reviewed tests ordered	1%	
Administration	E-management	4%	*I've made a lot more use of, our IT person helped, the bpac embedded in medtech.*
	Audit	3%	*Starting to audit my clinic record and make a protocol to avoid the chance of missing document.*
Other	Unspecified or technical change	8%	*[Changes were] some specific things about airway management.*
	Self-care	4%	*I have done a routine annual personal health check!*
None	No changes planned	4%	*I haven't made any changes it was just a waste of time*

Doctors were more likely to act on suggestions from the review if they considered the feedback relevant. As more doctors complete their second review there is an opportunity for reviewers to concentrate on the suggestions for change from the previous RPR and follow-up the doctor's progress in a positive way.

> *She did say I had clearly changed [the way I practice] so she was obviously familiar with my last RPR and she wasn't even the same doctor. So, it was really good of her to mention that sort of thing. (Second RPR)*

Case study example: First review

Dr E runs a medical business and no longer sees patients. As his role did not involve clinical practice he was worried that the review would not suit him. Dr E thought the reviewer would be judgemental because he was not practising and might put limitations on his practising certificate.

> *I just felt it was a heap load more paperwork which was unnecessary to do and I wouldn't get anything out of it.*

Despite his negative view before the practice visit, Dr E found it to be *"really good"* and appreciated self-care being included in the review. He knew he was too busy at work but had not taken any steps to reduce his workload. After hearing from a reviewer that he needed to slow down, he made changes leading to a reduction in his workload.

> *To have someone from outside who doesn't know me and come in and say, "you need to do this" was really important to me…. You hear your wife nag about it all the time and you can put it to the side, but to hear a stranger say it was really good.*

Overall, Dr E was surprised how useful the RPR was and thought it was worthwhile.

> *It was positive, I was really surprised that it wasn't just a beat up like most of these things are…. It was a real relief it wasn't painful and that it was constructive, so it was really good.*

6.3 Doctors maintained changes twelve-months later

We examined the extent changes were maintained by comparing the 261 doctors who by the end of June 2019 had completed **both** the post-RPR survey and the survey twelve-months later.

In the Post-RPR survey 48% of doctors reported making changes to their practice. After twelve-months this reduced slightly to 41% (Figure 19). Most doctors who made changes made them soon after their review.

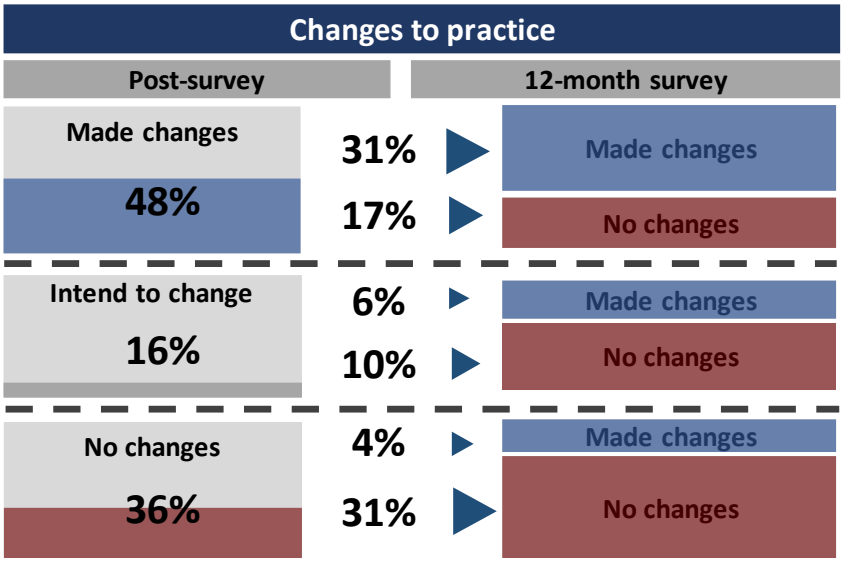

Figure 19. Changes to practice due to RPR over time (Post-RPR and 12-month survey, n = 261, first RPR). The left side of the diagram shows the initial percent of doctors who reported making changes to their practice, intending to or not making changes. The right side shows what these different groups of doctors reported in their 12-month survey.

6.4 Learning new opportunities was closely linked to making changes

At twelve-months, learning about new opportunities for development following a review appeared to be closely linked to the likelihood of making changes. More doctors who considered their report to be accurate made changes to their practice (52%) than those who did not consider the report to be accurate (21%) (Table 10).

Table 10. Quality of feedback compared to changes made and overall impression of RPR (Post-RPR survey, latest RPR only) (Statistically significant differences in proportions are in bold, Pearson Chi-Square < 0.05)

	Number of doctors	Have made changes to their practice	Have made changes to their PDP	Would recommend RPR
Learning new opportunities				
Learned new opportunities for development	320	**64%**	**56%**	**72%**
Learned no new development opportunities	234	**18%**	**34%**	**32%**
Reviewer's skill				
Agree the reviewer had the appropriate skills	463	**49%**	**49%**	**63%**
Neutral or disagree the reviewer had the appropriate skills	90	**20%**	**35%**	**8%**
Report accuracy				
Agree the report was accurate	416	**52%**	49%	**65%**
Neutral or disagree the report was accurate	137	**21%**	41%	**23%**

6.5 Doctors' contexts and demographic characteristics influenced the likelihood they would make changes

General practices can vary in the number of doctors and other staff, patient loads, demographics of the patient population and levels of managerial/supervisor support. Doctors can also hold different positions within practices, for example owning the practice or working as a locum.

Overall, doctors working in general practice were significantly more likely to report making changes to their PDPs and practice (Table 11) than doctors working in other settings such as hospitals or clinics specialising in other branches of medicine. Doctors with fewer years in practice and doctors who did not speak English as a first language were also more likely to have made changes to their practice following their review. A doctor's place of training was not associated with whether they had made changes to their PDP, their practice or whether they would recommend RPR to their colleagues.

Table 11. The influence of demographic factors on doctors' responses to RPR (Post-RPR survey for doctors latest RPR only[17]) (Statistically significant differences in proportions are in bold, Pearson Chi-Square < 0.05)

		Number of doctors	Have made changes to their PDP	Have made changes to their practice	Would recommend RPR to their colleagues
English as a first language	Yes	343	47%	**41%**	54%
	No	126	47%	**54%**	59%
Years in practice in New Zealand	≤10 years	217	44%	**49%**	58%
	11-30 years	194	49%	44%	53%
	30+ years	55	47%	**29%**	51%
Trained in New Zealand	Yes	180	47%	41%	52%
	No/unknown	289	47%	47%	57%
Medical branch	Working in general practice	230	**52%**	**52%**	56%
	Not working in general practice	239	**42%**	**38%**	64%

[17] Years in practice has a different total due to missing values.

Case study example: First review

Dr F trained and had worked in New Zealand for more than 20 years. She had completed postgraduate qualifications in her specialty but did not belong to a professional college.

Prior to her role at the time of her interview, Dr F worked in relative isolation. She relished the chance to be reviewed by peers as she felt it was an important way to continue practising safely. Dr F also thought a review could be helpful even for doctors who are members of professional colleges. She saw the value of RPR as supporting doctors who work in isolation rather than those with fewer qualifications.

> *I think it's a great idea for people who work in isolation. I certainly think there is nothing to fear from peer review.*

When interviewed Dr F worked had moved to a different workplace setting and was in a large multidisciplinary team surrounded by others in her speciality. She believed in this setting she was reviewed continuously and RPR would not add anything. Dr F felt her concerns were confirmed after the practice visit as her reviewer did not identify any areas for further development and she was already aware of the strengths highlighted by the review. Dr F did not create any e-portfolio goals following her review.

7. RPR helps assure Council that competence is being maintained

On average most RPR ratings were high across all domains (records/requirements, doctor/patient relationship, clinical reasoning and clinical practice). One-quarter (25%) of doctors recorded consistently 'superior' RPR ratings across all 13 RPR categories. A very small proportion had consistently low ratings across many of the 13 categories.

In the retrospective survey, three-quarters (74%) of doctors who had been reviewed were still practising under general registration. Of the remaining 26%, half (13%) had become members of a professional college. Approximately one-quarter (23%) of doctors who were no longer practising under general registration said their RPR had been part of the reason they changed.

7.1 Doctors received high RPR ratings

Doctors had a mean RPR score of 6.72 out of 9[18]. Most doctors scored six or above out of nine for most ratings (Table 12). Some aspects of practice that stood out as having fewer superior ratings were:

- Notes facilitate continuity of care.
- Record is clear, accurate, has required information.
- Clinical practice examination.

[18] Based on RPR report ratings for doctors on a scale of one to nine over thirteen categories scale (1-3 = unsatisfactory, 4-6 = satisfactory, 7-9 = superior).

Table 12. Percentage of doctors in each RPR rating category (latest RPR only, n = 814-838)[19]

RPR rating scores	Unsatisfactory	Satisfactory			Superior
	1-3	4	5	6	7-9
Records/requirements (n = 817-838)					
Ability to competently navigate and use PMS	0.4%	2%	12%	31%	55%
Notes facilitate continuity of care	2.4%	4%	11%	29%	53%
Records show appropriate standard of care	2.2%	4%	12%	27%	56%
Record is clear, accurate, has required information	2.2%	3%	11%	31%	53%
Doctor/patient relationship (n = 827-828)					
Engaging the patient	0.1%	1%	6%	25%	68%
Responding to the patient	0.1%	2%	6%	26%	67%
Listening to patient	0.1%	2%	7%	27%	63%
Clinical practice (n = 809-821)					
Clinical practice management	0.2%	2%	11%	27%	60%
Clinical practice history	0.4%	2%	11%	30%	57%
Clinical practice examination	0.5%	3%	13%	31%	53%
Clinical reasoning (n = 814-821)					
Clinical reasoning for their management	0.4%	2%	10%	26%	61%
Clinical reasoning for investigation	0.2%	3%	11%	30%	55%
Clinical reasoning for diagnosis	0.4%	2%	11%	31%	56%

Approximately one-quarter (25%) of doctors recorded consistently 'superior' RPR ratings (seven and over) across all 13 RPR categories (Table 13). A very small proportion had consistently low ratings across many of the 13 categories. There were no significant differences between the demographic profile and practice type of low scoring doctors compared with others.

[19] The number of doctors varies as if an area did not have relevance to the doctor's area of practice there was no rating recorded.

Table 13. Percent of doctors who consistently had ratings below five, six and seven from all thirteen RPR categories (all categories are rated on a 1 to 9 scale) (latest RPR, n = 844)[20]

	None	1 - 2	3 - 4	5 - 6	7 - 8	9 - 10	>10
Ratings below 5	87.6%	5.9%	4.1%	1.4%	0.2%	0.2%	0.5%
Ratings below 6	61.4%	13.7%	11.0%	5.1%	3.3%	2.0%	3.4%
Ratings below 7	25.4%	12.0%	13.3%	10.2%	9.7%	10.1%	19.4%

7.2 Doctors' RPR ratings improved for their second review

A direct comparison between a first and second review was possible for 192 doctors and their mean RPR score increased significantly ($p<0.05$) from 6.73 to 6.89 out of 9.00. Average scores increased across all RPR domains (records, doctor/patient relationships, clinical reasoning and clinical practice).

When individual doctors were considered, 10% more doctors had average ratings above seven and fewer doctors had lower ratings (Figure 20).

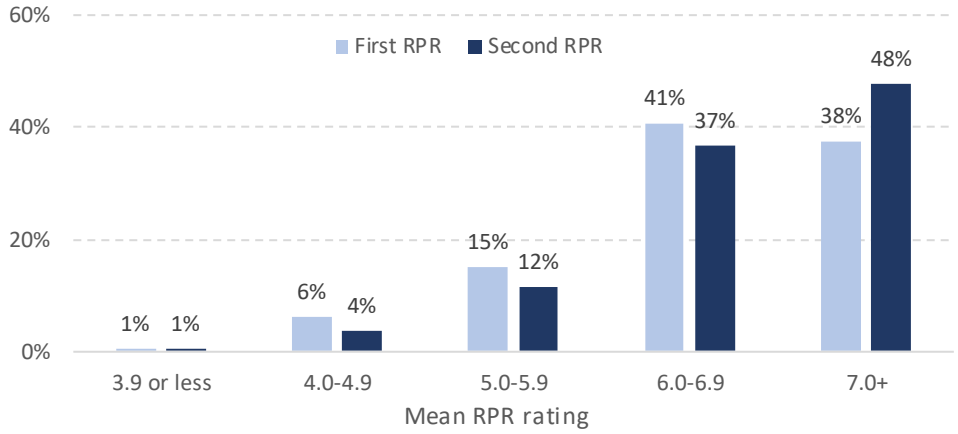

Figure 20. Change in mean RPR rating[21] between first and second RPR (n = 192[22])

[20] Note that some doctors did not have ratings for all categories

[21] Based on RPR report ratings for doctors on a scale of one to nine over thirteen categories scale (1-3 = unsatisfactory, 4-6 = satisfactory, 7-9 = superior).

[22] Only includes doctors who completed two RPR and had ratings present for both RPR.

Slightly over half (51%) of doctors had an increase in their mean RPR score between reviews, with 15% increasing by more than one point. One in three (31%) doctors also had a decreased average score (Table 14).

Table 14. Percent of doctors with changed average RPR scores between first and second RPR (n = 192)

Decrease in score by >0.2	No change ±0.2	Increase in score by >0.2
31%	18%	51%
Decrease 0.21 - 0.5: 11% Decrease 0.51 – 1.0: 10% Decrease >1.0: 10%		Increase 0.21 - 0.5: 16% Increase 0.51 – 1.0: 21% Increase >1.0: 15%

7.3 Some doctors joined professional colleges

In the retrospective survey, all doctors who had taken part in RPR after five years were asked what their current practising situation was in June 2019. Three-quarters (74%) reported they were still practising under general registration, while 26% were not (Figure 21).

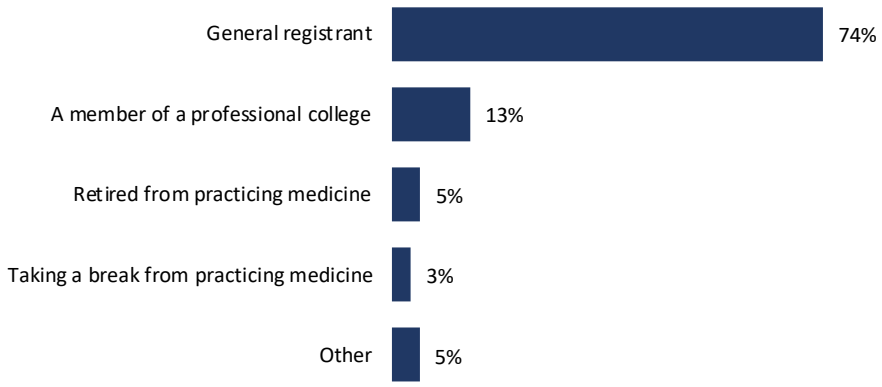

Figure 21. Current practising situation for doctors responding to the retrospective survey (n = 496)

Doctors who were no longer practising under general registration were asked if RPR had anything to do with their change. Approximately one-quarter (23%) reported the RPR had been part of the reason they changed.

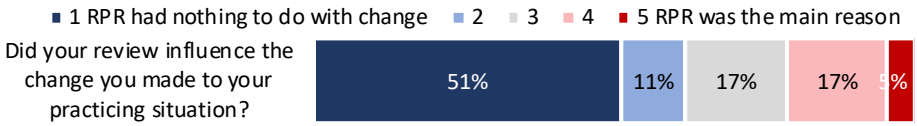

Figure 22. What impact RPR had on why doctors changed their practising situation (n = 131)

8. RPR is likely to be improving the quality of care being delivered to patients

Reviewers were confident their feedback led to changes in practice that would improve care for patients. In response to the post-RPR survey, 43% of doctors thought participating in RPR improved the care they delivered to their patients and 52% reported it helped in other ways.

Changes in practice and professional development plans resulting in improved quality of care are likely to be improving patient outcomes but the impact of changes on patient outcomes cannot be assessed.

RPR aims to improve outcomes for patients by improving the quality of care they receive. The impacts of changes in practice on patient care are complex and hard to quantify. The evaluation has drawn on reviewers' opinions and reviewed doctors' assessments of the extent they considered RPR may be improving the quality of care for patients.

8.1 Reviewers considered RPR is likely to improve the quality of care for patients

In response to the 2019 reviewer survey, 20% of reviewers strongly agreed that RPR was likely to improve the care delivered to patients and 57% agreed (Figure 23).

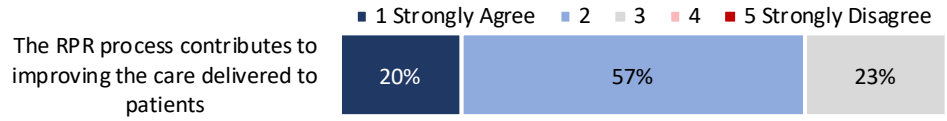

Figure 23. Reviewers' views on whether RPR contributed to improvements in care delivered to patients (2019 reviewer survey, n = 30).

8.2 Slightly under half of reviewed doctors considered RPR improved patient care

In the RPR survey and interviews, doctors often reported they had made changes in response to RPR. After their first review 43% of doctors thought participating in RPR improved the care they deliver to their patients and 52% that it helped in other ways (Figure 24). Just over one-quarter disagreed that RPR had improved the care they delivered to their patients.

> *There was no change [in my practice] whatsoever after the first one. (Second RPR)*
>
> *It is important to be open to feedback from other colleagues, this enhances self-awareness and can improve the care we provide for our patients. (First RPR)*

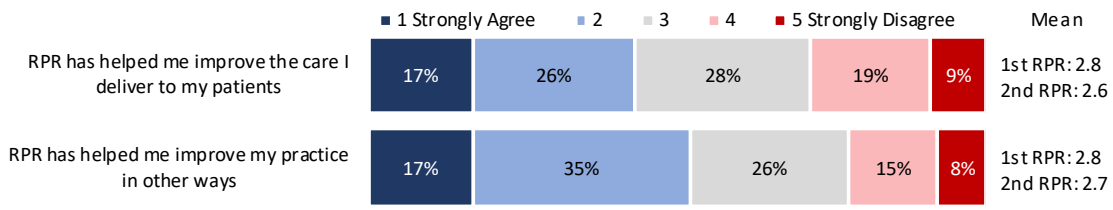

Figure 24. Doctors' views on the impact of the RPR (Post-RPR survey, first RPR only n = 446).

8.3 Evidence about improved practice quality suggests improvements in patient outcomes are likely

Doctors have made changes to their professional development and to their practices that are likely to directly or indirectly contribute to improved quality of care and patient outcomes.

Some examples of how changes made following RPR could help patient outcomes are described below.

- Review of prescribing habits: some doctors spoke about changing their prescribing habits to align with best practice which may result in better patient outcomes.

  [I have] Reviewed my prescribing of Augmentin and have looked for other appropriate antibiotic alternatives. I thought this a most valid critique, and when discussed with our continuing education group of some 16 doctors we all accepted we all needed to do this. (First RPR)

- Better notes: could potentially lead to better care of patients and better patient outcomes, especially when a patient sees different doctors.

  One of my goals [from my first RPR] was how to write good notes. And I thought for me the best thing, was instead of typing, because I'm not the best, was to equip myself with modern technology, and so I have Dragon [speech typing software]… and I write an enormous amount of notes when I dictate my notes when I'm finished with a patient. That was fantastic. (Second RPR)

- Improved self-care: could reduce the potential for errors by tired and stressed doctors.

  [Have you made any changes to your practice because of your most recent RPR?] Absolutely, I always make changes. I make changes in the medication I use, I make changes in the practice where I'm working at. The last time four years ago I actually changed cities because it became so blatant that the whole travelling for a long time was becoming too stressful. (Second RPR)

9. Key elements of an effective review

Effective review processes identified through the evaluation comprised:

- Understanding the purpose of the review: Clear communication of RPR as a quality improvement initiative and a collegial approach to the review.
- A well-defined review process: That left doctors feeling the reviewers had been able to get an accurate view of their practice through the information provided before the visit (the multisource feedback) and the practice visit.
- Well trained and supported reviewers that provided the doctor with confidence the reviewer has the skills to properly understand their practice.
- Review feedback and report that reviewed doctors considered relevant and provided useful information on which they could act.

Maintaining relevance of the review is more challenging for second reviews, especially for doctors who received mainly superior ratings in their first review.

9.1 Clearly communicating RPR as a quality improvement initiative.

Before they participated, doctors held mixed views on the usefulness of RPR. Before their first review, approximately one-third (31%) of doctors thought the reviews would be useful. This proportion remained similar throughout the evaluation. The ease of organisation, how well the RPR process fitted the individual doctor and how well the practice visit went could influence doctors' experiences of the process and contribute towards their response to their review.

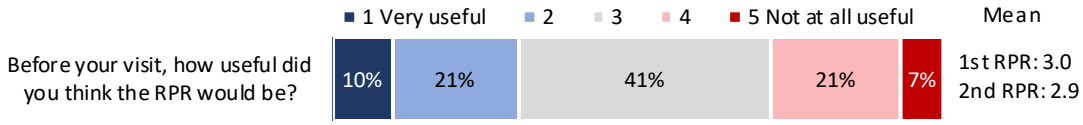

Figure 25. How useful doctors thought the RPR visit would be prior to their review (Post-RPR survey, first RPR n = 446).

Doctors' understandings of the purpose of RPR also influenced their expectations of the programme and their attitudes to feedback. Misunderstanding the purpose of the review (seeing it as a pass/fail practice audit) appeared to contribute to reviewed doctors placing a higher importance on the expertise of the reviewer in their area of practice.

Doctors were more positive about RPR after their review. Over half (58%) said they would recommend RPR to their colleagues (Figure 26). Doctors said they changed their opinions about RPR because their review had provided reassurance about their practice, they valued the opportunity to have an objective perspective on their practice from a senior colleague, and/or they learnt about new development opportunities.

Not as painful as I thought, a much more useful process than I expected. Thank you to all. (First RPR)

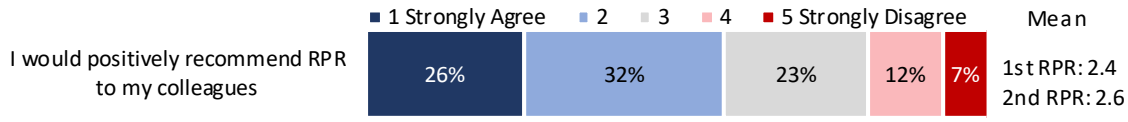

Figure 26. Would participating doctors recommend RPR (Post-RPR survey, first RPR n = 446).

Case study example: Second review

Dr G was working full-time in general practice and had recently completed her second RPR. Before the latest review the reviewer contacted Dr G to clearly outline the process and the goal of the visit which helped set up positive expectations for Dr G and the rest of her practice. She said this was much better than her first RPR where there was very limited contact beforehand.

This one the doctor let me know in advance, he was communicating with us in advance of the visit, and was reassuring to me, and the whole practice that that we should be pretty laid back and not be too stressed by it. He reassured us in advance that he was coming to be more of a supportive role rather than a critical role. And that was really nice because it set the pace for that day. And we knew well and advance, we knew exactly what to do, he let them know, he set the time schedule. It was perfect actually, it went perfectly. That was nice compared to the first one.

The first one there was no communication with the practice manager, this one was very well organized… [the reviewer] contacted the practice manager on his own.

9.2 Creating a collegial and comfortable environment

Many doctors talked about how important it was to create a collegial experience during the RPR. This helped doctors feel more at ease and made the day a positive experience. Some doctors talked about feeling less anxious for their second review as they knew what to expect but many were still nervous.

Case study: The importance of a collegial environment: First review

Dr H had been practising medicine for over twenty years of which half had been in New Zealand. Dr H accepted that having a RPR was part of the process to stay registered but was a little apprehensive.

I thought it would be quite nice to see what he thinks of my work and I thought it would be quite good to hear what he's got to say about it and if he would have had something to say even if it was critical, that would be good criticism, because… I respected him and I think it would be quite good to hear what he has to say.

Dr H thoroughly enjoyed his practice visit, he felt that the collegial atmosphere his reviewer created was very important for the success of the RPR.

> *It was actually probably easier and better than what I expected... In some ways it was actually quite nice, it was actually positive and I didn't expect that. I thought I would feel like a teacher was following me around and criticising what I was doing. I felt in some ways it was more like I felt like I had another colleague beside me who would discuss things almost on even level.*

The reviewer achieved this positive atmosphere by taking his time and not rushing through anything. The reviewer firstly outlined how he hoped the day would go and then described what he was there to do and that he was there to support Dr H. It was important for Dr H that his reviewer took the time to understand his career choices and how he got to where he was.

> *The reviewer talked about what we were going to do with the day and what his thoughts were around how we could do that. He outlined a bit… "I'm not here to criticise you…, but I'm here as a colleague and maybe there are things we can improve". He was open about what he was trying to do and it… put me at ease.*

After his review, Dr H understood how to manage his PDP better and had made changes to his practice. Overall, Dr H found the RPR visit much better than he anticipated and found it very useful for discussing his PDP and practice, feeling supported and having a positive collegial discussion about patients. He thought the RPR covered all aspects of his work.

> *Quite honestly I don't know [how it could be improved]… he did look at my letters, he checked in with me, he watched me see patients... he watched me in a meeting, and I had to give feedback about certain stuff, I think he did his job…*

Case study: The importance of a collegial environment: Second review

Dr I has now been reviewed twice. She enjoyed her first review and learnt from the experience but felt her second was a disappointment. Her first reviewer had some interest in Dr I's niche area of practice whereas the recent reviewer did not.

> *My experience this time was totally different to my first one. The first person was… friendly and collegial, so I was hoping it would be quite similar, but it wasn't at all.*

Her first reviewer created a collegial environment with a reciprocal exchange of ideas and knowledge which facilitated positive, peer review like discussions about patients and discussions on Dr I's current CME. She was hoping to have another productive collegial day. In contrast, Dr I felt her second review was not collegial and more of an exam/test situation. Although the reviewer did suggest a few potential minor improvements with which Dr I agreed, she did not feel it was worthwhile.

> *The biggest issue I had was that it wasn't a normal interchange of conversation, it was just more questions and criticisms.*

It can be really good. I found the first one really good and interesting. When he sat in with me he helped with patient diagnosis and discussed cases with me, so that was quite helpful. The second one was more a critical analysis and I didn't feel I really gained anything from it.

So, it was drastically different experiences. I think it's got really good potential and I found the first excellent and the second not so much. I think it's really important to find someone that is suitably matched perhaps.

9.3 Well trained and supported reviewers

Well trained and well supported reviewers underpin the effectiveness of RPR. The reviewer has a crucial role in influencing the perceived value of RPR and the extent doctors make changes following their review.

Most reviewers had between 20 and 40 years of practice experience. Almost all (93%) of the reviewers surveyed were still in clinical practice or had recently left.

Reviewers were positive about their roles with nearly all surveyed reviewers agreeing the role had been a positive experience and had improved their own practice (Figure 27). Most reviewers (80%) felt they were completing about the right number of reviews, while some wanted more and others fewer.

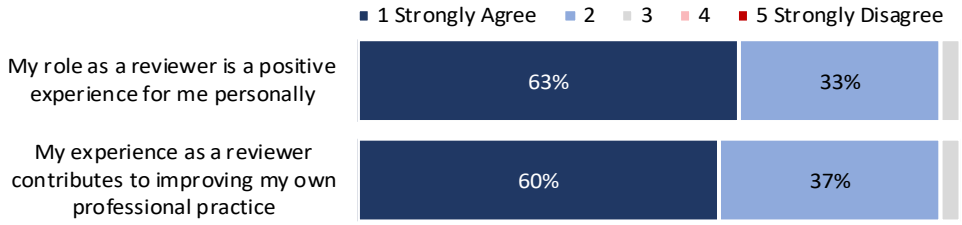

Figure 27: Reviewers' views on how positive the role is and if it contributes to their own practice (2019 reviewer survey, n = 30).

Reviewers were also positive about the respect and value others in their profession placed on their role as reviewers (Figure 28).

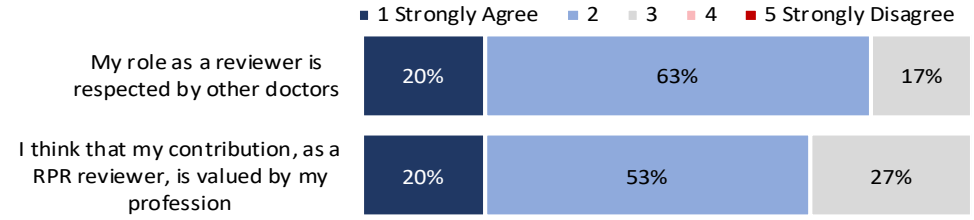

Figure 28. Reviewers' views on the perception of them among other doctors (2019 reviewer survey, n = 30).

Giving feedback is a skilled role. Developing the reviewer's ability to provide feedback on opportunities to develop the reviewed doctor's practice has been a focus of reviewer training. RPR reviewers thought they had the necessary support and training to carry out

effective reviews and had sufficient information about the doctor being reviewed (Figure 29).

> *It has been very helpful to have someone experienced to talk things over with and develop a plan together. [bpac^{nz} supervisor] very supportive. (Reviewer)*

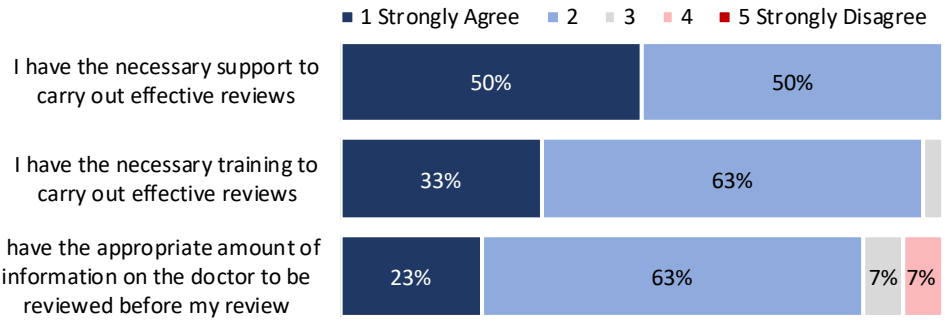

Figure 29. Reviewers' views on their preparation for the reviewer role (2019 reviewer survey, n = 30).

Most doctors reviewed for their first time (84%) considered their reviewer demonstrated appropriate skills to evaluate their practice (Figure 30). Doctors considered their reviewer to have the necessary skills as a reviewer if they were senior doctors, demonstrated their knowledge, had experience in the doctor's type of practice and could create a collegial experience.

Reviewed doctors highlighted the value of an objective view on their practice from someone they respected.

> *[He] was great to talk to, very easy to get along with…. what he's done is that he's done the exact same thing [as me] except he's gone down [a different route]. So, from the GP world and has gone into a small area of medicine. So, he got it completely, so that was great. It didn't matter that he didn't have the content knowledge of what I do, it just didn't matter. (First RPR)*

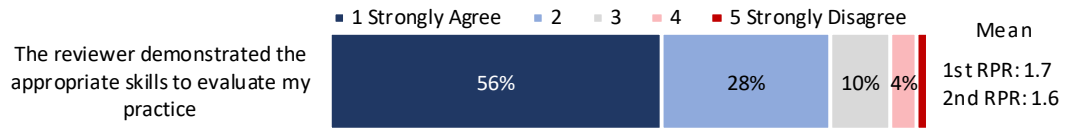

Figure 30. Doctors' views on their reviewer skills (Post-RPR survey, first RPR n = 446)

A recurring theme throughout the evaluation was the challenge in matching reviewers with a small number of RPR participants in atypical practices. If 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 characteristics of their practice into account, and why the reviewer is qualified to undertake the review then the mismatch was less of a problem.

> *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. (First RPR)*

I think the key thing is you are getting assessed by your peers. I think if I had a doctor who had worked in the hospital for 20 years and he came to my general practice to do it I wouldn't be comfortable with that. I would be worried about his understanding and insight into general practice. But when you are dealing with a colleague who understands the context. Like, GPs speak our language and would instantly know if something is out of place whereas someone else wouldn't. (Second RPR)

The percent of doctors agreeing that their reviewer demonstrated the appropriate skills to evaluate their practice has slightly increased since the start of RPR (Figure 31) suggesting the training and growing experience of reviewers is addressing earlier concerns about mismatches. There was no significant difference in the proportion of doctors working in general practice and those in other types of practice who considered their reviewer demonstrated appropriate skills to evaluate their practice.

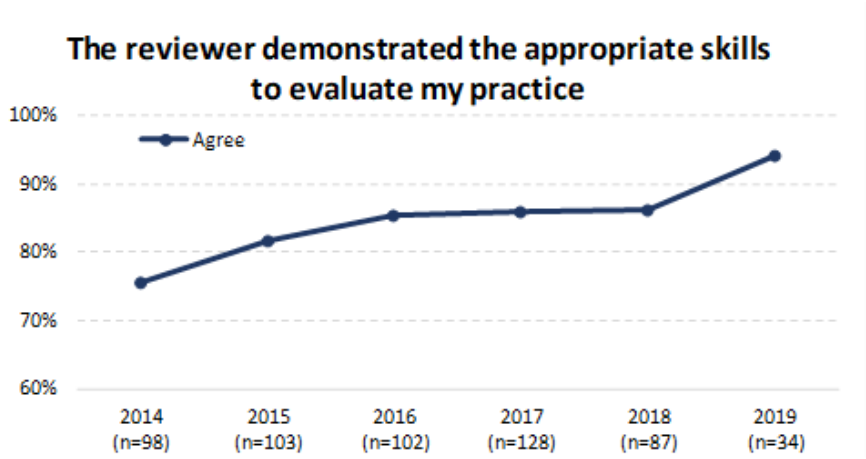

Figure 31. Percentage of doctors agreeing their reviewer had the appropriate skills over time (Post-RPR survey, all RPRs n = 552)

Linking post-RPR survey responses from doctors to their reviewers highlights the differences reviewers can make to whether doctors make changes following their review. The top row of Table 15 shows the highest percent of positive outcomes that any reviewer achieved while the bottom row shows the least positive outcomes any reviewer achieved. For example, 14% of the doctors reviewed by one reviewer reported making changes to their practice while 71% of doctors reviewed by another reviewer reported making changes to their practice.

Table 15. The range of different outcomes for doctor's responses linked with different reviewers (includes reviewers active in last twelve-months who have completed five or more reviews in total (reviewer n = 18, reviewee n = 322)

Reviewer with…	Drs made changes to practice	Drs made changes to PDP	Drs learnt new development opportunities	RPR a positive experience for Drs	Drs positive about reviewer's skill
Maximum percentage	71%	71%	100%	100%	100%
Median percentage	40%	40%	56%	74%	91%
Minimum percentage	14%	17%	35%	55%	64%

The number of reviews completed by a reviewer was not a factor in differences between reviewers. Potential reasons for the variation between reviewers included:

- Some reviewers only review certain types of doctors (administrative, teaching, academic, business owners, hospital-based specialties etc.) which may make it less likely that a doctor would change or be able to change their practice or PDP.
- Interviews with doctors showed that some reviewers were less successful at making the visit a positive experience, this may indicate there is room to improve the skills and approaches of some reviewers.

9.4 Review and feedback processes that doctors consider are relevant and useful for them

The perceived costs of a review to a doctor compared to their views of the benefits influenced their attitudes to the relevance of being reviewed. Doctors either thought their review was a good or poor use of resources, both of their own time and the cost to bpac^{nz}.

> *It would have cost a lot of money to send this guy to spend four hours with me. We could have done it on the phone. So needless to say, it wasn't a very valuable exercise. (First RPR)*

Some doctors did not consider that a review was relevant for them. Some saw themselves as already highly competent and saw no need to be reviewed. Some felt they worked in settings where peer review was already present and readily available. Others saw the need for the programme and thought it would be useful.

> *I thought it was a bit ludicrous really, especially as I'm in a non-clinical role, so I can't see any benefit for man or beast. So, it just wasn't appropriate for me. (First RPR)*

Doctors who learnt new opportunities for development in their report or agreed their reviewer demonstrated the appropriate skills were significantly more likely than those who did not to make changes to their practice, to their PDP, and be more positive about RPR.

There were additional challenges to ensuring doctors considered their second review useful, especially for doctors who had received all or mostly all superior ratings in their first review.

> *It is not very gratifying to have 40 years of experience in general practice and still being made to prove myself. That being said, the results of the surveys were informative. The visit went well - my reviewer was very nice and did not make the process at all stressful - but I am not sure why repeated visits are necessary (Second RPR)*

Effective feedback is feedback in which information on previous performance is used to promote positive development. It should be planned and delivered in an effective manner and suggestions for change should ideally be linked to the doctor's previously identified strengths and weaknesses as it makes any suggestions more relevant.

Case study example: The relevance of the second review: Second review

Dr J has practised for nearly 40 years and has spent the last 15 years working in two different areas of practice. After having a successful and positive first review three years ago, Dr J was looking forward to her next one.

> *I must say the first one I had was just so good, so I wasn't apprehensive at all about the second one.*

Dr J thought the first review was good because the reviewer suggested changes to help improve her practice. These included antibiotic use, being more aware of privacy during consultations, having a standard format for taking notes, how to do an audit of notes and a range of other small things.

Dr J liked the way the second reviewer commented on the changes she had implemented after the first RPR and made additional suggestions to improve her practice and PDP. Dr J also appreciated the inclusion of personal care in the review. She also thought it was good the reviewer spoke to her CRP on the day to get a wider impression of how she practised.

> *The RPR is also about looking after yourself and I must admit I have cut my hours down since the last RPR. I used to do four nights a week now I do two.*

Dr J found the review collegial, accurate and covered her whole practice. She thought RPR or a similar review process would be useful for all doctors.

> *For each section, she would write what was good and then things that could be improved on. She had a really good handle on how I was working. We had never met before, but it seemed like she knew what I was doing and how I was doing it.*
>
> *I think every doctor should have something [like this]… like if there was a high up consultant it might be quite hard for a nurse to correct them or another colleague to say excuse me I think it might be good to do things this way.*

Case study example: Regular RPRs are helpful: Second review

Dr K has been working in general practice for 20 years, the last five of which were in New Zealand. Dr K had a good experience during his first RPR and was looking forward to his second review.

> *I like that it's a one on one sparing time with the examiner, I love that… You never ever really have the time to have somebody all day with you because we are all too busy and it doesn't let you run into the wrong direction for a long time.*
>
> *It's always good to bounce ideas off to see if you are doing things correctly or not. I'm always trying to learn ways to be better. Better, safer, more knowledgeable, whatever.*

Dr K said he made multiple changes to his practice and PDP including refining his prescribing of certain medications and making his PDP goals SMART goals, but the biggest change was to his career plan to become a fellow.

> *The first examiner said that isn't really needed [joining a college] so I was like "okay". This time around she said I think it would make sense [to join a college] because you are really good, you have lots of assets and obviously are really interested in doing what I am doing so it was different I suppose.*

Dr K has applied to become a fellow and is looking forward to starting his training. He hopes that he can continue to have something like the RPR as often as possible. Dr K said he has a great CRP but the RPR provides hands on feedback.

> *In New Zealand one thing is everyone is so busy, you work alongside people but you have hardly any time to talk… But this was immediately when I had a question it was 'how can we make this better, what would you do'. I found it incredible, I would love that every year.*
>
> *I can have an excellent collegial relationship person which a doctor I've been working with for the last five years which I treasure and he really knows me well and he knows the growth which is really great but it's not like he has the time to sit next to me all day long.*

10. Overview

RPR is now an established programme which general registrants take part in every three years. RPR helps support doctors practising under a general scope of medicine to enhance their professional development and make positive changes to their practice.

10.1 Reviews are improving professional development and practice

Being reviewed is helping doctors to identify new areas for development and 57% of doctors said they planned to adjust their PDP to address these areas for development.

Doctors are making changes to their practice following their reviews that have the potential to improve patient outcomes. For example, improved self-care may help doctors to perform at their best, changing prescribing habits to best practice could directly help patient outcomes.

In a very small number of cases when concerns are raised following a review, there are processes in place for remedial action.

10.2 There is the potential to strengthen RPR processes

RPR is viewed as useful by 52% of doctors but other doctors still view it just as an exercise they must complete to comply with their recertification requirements.

Surveys and interviews suggested the most important element of a review was that the reviewed doctors saw their review as relevant and accurate. Aspects of RPR where there is potential for improvement to enhance the extent reviewed doctors considered their review relevant and accurate are:

- **Providing more clarity that the purpose of the review is quality improvement**. There are opportunities to influence doctors' expectations of RPR through the communication sent to doctors selected to participate in RPR. For example, emphasising RPR's focus on quality improvement may improve doctors' expectations of RPR before they participate and reduce their anxiety. Many doctors reported this was already the case but there was always a level of anxiety before assessments.
- **Considering the potential to strengthen multisource feedback.** Although patient feedback provided some doctors with reassurance, the uniformly positive feedback did not provide an effective mechanism to identify opportunities for quality improvement. There may be potential to review the patient feedback questionnaire to improve the extent it identifies opportunities for development.

  Some doctors struggled to get the required feedback from colleagues as they were not sure who was appropriate to ask, this was especially common for locum

doctors. It could be helpful to have a commonly asked questions section when reminding doctors about patient and colleague feedback.

- **Reassuring doctors about the reviewer's role and expertise**. Some doctors, particularly in atypical practices, were concerned about how RPR would work for their practice. The skill of the reviewer and the extent to which the reviewed doctor respects the reviewer's experience and knowledge of their practice type are very influential in whether the doctor makes changes and how useful they think the RPR was for them. While it is difficult to find reviewers for the small number of more unusual practice settings, the reviewer's attitudes and training are important in overcoming the reviewed doctor's reservations.
- **Reviewing the timing of second and subsequent reviews for doctors who rate very highly**. Learning about new opportunities for development contributes to satisfaction with the review process. As approximately one-quarter of doctors received 'superior' RPR ratings across all categories it may be difficult to provide new opportunities for development for these doctors. While some welcomed confirmation that they were providing a high standard of practice, others felt the process was not worthwhile, especially not every three years. Exploring options for information to include in the review reports for these doctors would strengthen the value of the RPR process. Options to be explored might include generic information about how to improve self-audit processes, ways to explore new opportunities for innovative practice and/or linkages to ways these doctors could mentor and support their colleagues.

There is also the potential to further support doctors to make changes by:

- **Reviewer follow-up after the review**. Some reviewers wanted more follow-up with the doctors they reviewed, potentially in the form of a phone call to support practice changes and hear about the result of their work. It was also suggested that there be a more formal process to follow up on suggestions made in previous RPR reviews.
- **Strengthening the CRP role by providing professional development about expectations and how to support colleagues.** The CRP was the person with whom reviewed doctors most commonly discussed their professional development plans. CRPs could be further encouraged to concentrate on addressing feedback from the RPR report and discussing what type of professional development could best address the feedback. This could help to reaffirm/consolidate the feedback and provide encouragement from multiple sources. However, comments from reviewers, RPR doctors and their CRPs highlighted variation in the quality of the collegial relationships. It is important to consider the extra time commitment if more RPR follow-up is expected whether from CRPs or reviewers.

  In response to this feedback a project was completed by MCNZ to improve the quality of collegial relationships. There is now clear guidance on the role and

expectations of collegial relationship providers and this includes the requirement to discuss RPR report feedback at collegial relationship meetings and a prompt within eport to record the discussion and the PDP changes as a result.

In interviews and in response to the survey, reviewers provided feedback about potential ways to strengthen RPR. Their feedback is summarised in Appendix Four.

Appendix One: Logic Model

Long-term outcomes

- Patients have confidence that they will be provided with effective clinical care
- RPR improves and assures the standards of New Zealand doctors

Medium-term outcomes

- Use of RPR becomes more widespread amongst medical professional organisations
- Changes made by doctors contribute to improved patient outcomes

Short-term outcomes

- Doctors select PDP activities that address identified learning areas and align with 'best practice'
- Participating doctors use information in RPR reports to inform PDP planning
- RPR is effective in identifying aspects of practice that can be improved
- Doctors recognise that RPR is a formative process and assess involvement as supportive and collegial
- Participating doctors engage with RPR

Outputs

- A continuous improvement process is in place for RPR
- General scope of practice doctors participate in RPR every three years
- Doctors maintain a CPD portfolio which includes a meaningful PDP

Activities (inputs)

- Processes are put in place to support doctors to develop CPD and to make positive changes
- Processes are put in place for remedial action if required
- RPR is implemented with general scope of practice doctors
- RPR is developed and pilot tested
- Reviewers are appointed and trained
- A RPR provider is commissioned

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

Appendix Two: 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 multi-source 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 • Doctors' 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 practice -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?	• Doctors' 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 practice • Doctors consider the report provides them with 'new' insights into how they could improve their practice	• 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 • Doctors' descriptions of changes they intend to make as a result of the RPR process and report • Doctors' descriptions 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?	• Doctors' PDPs 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 practice 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 practice?	• 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 practice	• 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 • Doctors' 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 practice?	• 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	• Twelve-month online survey of doctors • Twelve-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

Appendix Three: Evaluation strengths and limitations

The evaluation used a logic model and evaluation framework as a theoretical foundation. The mixed methods approach of combining analysis of bpac^{nz} data with interviews and surveys of reviewed doctors and reviewers contributed to the robustness of the evaluation. Triangulating self-reported information such as doctors changes to practice with reviewers' expectations and RPR ratings from bpac^{nz} data provides confidence that changes were happening.

Response rates to the survey and similar profiles between RPR participants and survey respondents (practice type and RPR scores) provide confidence that the sample included in the evaluation is broadly representative of all doctors reviewed over the evaluation period. However, there was limited demographic information to compare doctors who took part in RPR and those responding to the two-week survey. Doctors completing the post-RPR and twelve-month surveys were similar.

Table 16. Comparisons between all RPR participants and the evaluation survey participants

	RPR participants		Post-RPR survey		12-month survey	
	1st RPR	2nd RPR	1st RPR	2nd RPR	1st RPR	2nd RPR
Practice type - Based on bpac^{nz} designations:						
General practice	48%	85%	46%	88%	49%	96%
Other practice type[23]	52%	15%	54%	12%	51%	4%
Average RPR score[24]						
General practice	6.71	6.93	6.72	6.95	6.76	7.18
Other practice type	6.68	6.46	6.78	6.48	6.83	5.54
Number of RPR report ratings below seven						
None	24%	31%	26%	35%	28%	44%
1 – 2	12%	14%	14%	14%	13%	-
3 – 4	13%	14%	11%	15%	12%	-
5 – 6	11%	10%	11%	8%	12%	-
7 – 8	9%	9%	8%	8%	8%	-
9 – 10	10%	6%	10%	5%	9%	-
>10	21%	16%	20%	14%	18%	-

[23] Other practice settings included: Orthopaedic surgery, Internal medicine, Academic / Research, Other, Palliative medicine, Dermatology, Family planning and reproductive health, Occupational medicine, Psychiatry, Obstetrics and gynaecology, Medical administration, Public health medicine, Sexual health medicine, Urgent care, Travel medicine, Rural hospital medicine, Paediatrics, General medical and surgical runs, General surgery, Emergency medicine, Rehabilitation medicine, Vascular surgery, Sports medicine, Oral and maxillofacial surgery, Cardiothoracic surgery.

Appendix Four: Reviewers' suggestions for process improvements

The RPR process

The most common suggestion to reduce pre-visit anxiety as much as possible was to ensure the reviewer called the doctor well in advance to discuss:

- The purpose or RPR (emphasise quality improvement and that consultation and discussion of PDP are both important aspects)
- Outline the process on the day (customised for the doctors specific practice type)
- Talk about what the doctor wants to get out of the day
- Connect reviewers to other relevant people for the day to ensure managers know what to expect and have allowed for the doctor to have protected time.

Adjustments to RPR information:

- Emphasise observation of consultation is important but RPR can also be helpful for discussing; cases, future career planning, training opportunities, CME/PDP and audit clarification
- Reiterate the collegial nature of the visit and that the main purpose is quality improvement.

Improve information provided to reviewers beforehand

- Provide CRP contact details in the profile
- A simple two sentence description of what the doctors actually do (this is less relevant for general practice)
- Get a short, written summary from their CRP on the doctor's motivation and professional development in advance of the visit.

Adjustments to resources:

- Bring back the prescribing packs
- Improve the RPR booklet for recording information about mental health
- Make all forms completely online
- Continue to ensure reviewers are able to be flexible about the process and reporting to suit all kinds of doctors.

Potential to increase follow-up:

- Some reviewers wanted more follow-up with doctors to see and hear about progress and potentially have a more formal process to follow up on changes since first RPR.
- Have a feedback process from reviewed doctors to reviewers to help improve reviewer skills and practices. This may be challenging due to the power imbalance and low number of reviews completed by some reviewers.

Collegial relationship providers

Clear guidelines to ensure both doctors and their CRPs are aware of what is expected. Case stories could be used which outline poor and good CRP situations.

Professional development plans and other CME expectations
Provide clear and concise instructions on what PDP goals and audits are for and what they are expected to look like. A short video showing some examples and the expectations around goals could be an accessible format for doctors.
Increase promotion of RPR
Increase awareness of RPR as few doctors outside of *Inpractice* know about it. This includes information about the visit to ensure teams and managers know what the visit is about and how they can help to make it successful. Reviewers hoped this could help situations where doctors have been over scheduled for their RPR or not given a chance to interact with patients
The extent all doctors needed to be reviewed
Some reviewers felt that not all doctors needed a review or were getting much out of them, the doctors who some reviewers felt did not need a review included doctors: • About to enter training • About to retire • Practising at a very high level • Already heavily supervised e.g. in a teaching hospital. Other reviewers felt RPR should be expanded to all doctors.
General RPR processes
• More regular communication between reviewers: potential for teleconferences or discussion boards so all reviewers can learn from reviewers' experiences • A fully electronic form • More information about what follow-up is provided to doctors after recommendations are made • Overnight stay options for practice visits • Bpac^{nz} to provide more feedback about the reports produced • Ensure that reviewees and reviewers are continued to be matched as closely as possible.