Malatest International

Evaluation report

Evaluation of the Regular Practice Review Programme

March 2017

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Definitions and abbreviations

Abbreviation	Definition
bpac^{nz}	Best Practice Advocacy Centre, responsible for delivering RPR.
CME	Continuing Medical Education
CRP	Collegial Relationship Providers
PDP	Professional Development Plans
RPR	Regular Practice Review

Executive Summary

About RPR

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

Regular practice review (RPR) is a quality improvement process. Its primary purpose is to help maintain and improve the standards of the medical profession 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 has been implemented through the bpac^{nz} *Inpractice* programme since July 2013.

RPR involves:

- **Pre-visit**: Review of the doctor's professional development e-Portfolio, prescribing and laboratory test reports, a phone call with the collegial relationship provider and multisource and/or patient feedback
- **Practice visit**: Interviews with the doctor and in some cases colleagues, observation of consultations, review of records and clinical reasoning
- **Post-visit**: Report delivered to the doctor and Council summarising findings
- **Post-visit follow-up**: by bpac^{nz} with doctors where areas of concern or non-compliance with requirements were identified through the review.

The design of RPR is based on evidence about what is effective at improving practice. RPR has been implemented and 608 doctors have so far been reviewed. The initial focus was on doctors in general practice settings, whereas reviews completed during 2016 included a higher proportion of doctors in other clinical settings.

About the evaluation

The RPR evaluation provides mid-year and end of year evaluation reports. Previous reports include:

- Interim 2014 report – November 2014
- End of year 2014 report – March 2015
- Mid-year 2015 report – October 2015
- End of year 2015 report – February 2016
- Mid-year 2016 report – August 2016.

This report updates the mid-year 2016 report (provided August 2016) with information drawn from interviews and surveys of doctors participating in RPR and provides an overview of findings to date.

We invited all 445 doctors who completed RPR since the evaluation began to participate in the evaluation. This report draws on (with the number of new responses since the last report bracketed):

- 295 post-RPR survey responses (46 new) and 58 interviews (11 new), conducted shortly after doctors received their RPR report.
- 133 12 month survey responses (57 new) and 21 interviews (nine new), conducted approximately one year after the RPR. All doctors included in this report who completed the 12 month survey also completed the post-RPR survey.

Review, colleague and patient ratings were high for the majority of reviewed doctors

We analysed doctors' RPR ratings, colleague feedback and patient feedback results. We found:

- Over half of doctors had superior ratings and very few had unsatisfactory ratings
- Nearly all doctors were rated between four or five out of five in all categories by their colleagues
- Nearly all doctors were rated between four or five out of five in all categories by their patients.

Most doctors found participating in RPR a more positive experience than they expected

Before participating, approximately one-third of doctors expected RPR to be useful. Doctors who did not expect it to be useful thought the review would be a 'tick-box' exercise, were nervous about being assessed, uncertain about what to expect and/or felt they did not need to be reviewed.

Many doctors found participating in RPR a more positive experience than they had expected. Nearly three-quarters (71%) agreed it was a positive experience, two-thirds (67%) found the RPR report useful and more than half (57%) would positively recommend a review to colleagues.

Many doctors changed their opinion about RPR because they valued the opportunity to have an objective perspective on their practice from a senior colleague. Learning about new development opportunities, engaging in self-reflection and having

reassurance about their practice also contributed to doctors forming positive views about RPR. RPR report ratings did not appear to influence doctors' decisions about whether to positively recommend RPR to their colleagues.

Strengthening RPR

In early evaluation reports we anticipated the proportion of doctors who did not expect RPR to be useful would decrease over time as word spread it was a positive experience. This does not appear to be happening and RPR is still seen as an audit process by a substantial proportion of doctors.

Is there potential to further communicate RPR as a quality improvement process?

Doctors reported making changes to their practice following their review

After RPR, nearly half (46%) of doctors said they had made changes to their practice due to their review. A further 13% intended to make changes in the future.

The reviews did not suggest changes for all doctors. Doctors with high RPR ratings were generally less likely to receive feedback about new opportunities for development and less likely to make changes.

There was a small decrease in the proportion of doctors who reported changes to practice 12 months after RPR compared to shortly after RPR (42% compared to 51%).[1] The information suggests changes made in response to RPR were maintained for many doctors.

Doctors who reported making changes to their practice 12 months after RPR were more likely than those who had not made changes to:

- Have learned new opportunities for development
- Have made changes to their Professional Development Plan (PDP)
- Agree their RPR report was accurate
- Be positive about their reviewer
- Recommend RPR to colleagues.

Strengthening RPR

Many doctors reported making changes to their practice and professional development plans. While these are self-reported changes, they provide evidence that RPR achieves its aims for many of the participating doctors. Most doctors who had made changes as a result of RPR maintained these changes at 12 months.

[1] This result relates to doctors who completed both surveys to allow direct comparison.

However, few doctors who said they had not yet made changes after RPR but intended to do so had made changes 12 months later.

Would additional post-RPR follow-up for doctors with low and mid-RPR ratings support further changes?

Doctors changed their professional development planning following their review

RPR aims to improve the way doctors engage with professional development activities and planning. Around half of the responding doctors planned to adjust their PDP based on the results of their RPR. Doctors were more likely to adjust their PDPs to target new opportunities for development than to build on strengths. Half (50%) of the doctors who responded to the survey had already made changes to their PDPs as a result of their participation in RPR.

Half (51%) of the doctors who completed both surveys reported making changes to their PDP after RPR. The proportion decreased to 31% 12 months later. Changes included modifications to the way PDP was managed and planning PDP activities to align with RPR feedback.

Strengthening RPR

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 collegial relationship provider (CRP) is expected to provide guidance and mentorship for doctors registered in a general scope. Providing effective feedback for PDP requires skills and experience CRPs may not have. The extent to which changes in PDP result in changes in professional development activities may be increased with additional support for doctors as the CRP relationship varies.

Changes in the quality of care received by patients

It is difficult to measure the impacts of changes in practice and PDP on the quality of care patients receive. However, where changes in practice and PDP are in response to feedback from a review it is reasonable to expect they will flow through to improvements in the quality of care received by patients.

Just under half of doctors expected changes made following their review to contribute to improvements in the care they deliver to their patients (45%) and/or had improved their practice in other ways (53%).

Doctors' backgrounds, characteristics and personal views and experiences can influence their response to RPR

Likelihood to make changes to practice and professional development are influenced by doctors' characteristics, practice settings and experiences of RPR. Doctors were more likely to have changed their practice if they:

- Were doctors who work in general practice
- Did not speak English as a first language.

A minority of doctors did not acknowledge the value of a review. Some considered they were sufficiently experienced or adequately supervised/reviewed and would not benefit from the RPR. Some considered their selection for a review was unfair and believed all doctors should be treated the same.

Certain experiences of RPR were also associated with increased likelihood of making changes to practice and PDPs. Doctors were more likely to make changes if they:

- Agreed reviewers had the appropriate skills to review them
- Would positively recommend RPR
- Learned new opportunities for development
- Agreed their report was accurate.

Strengthening RPR

RPR is working effectively as a quality improvement tool for the majority of doctors being reviewed.

Some doctors receive very high RPR ratings and reviewers identify no or few new opportunities for development. This may reflect a need for reviewers to get more training in appropriately advising this group. The frequency of re-review could also be reconsidered for this group.

Ensuring that the feedback is given in an effective manner and that the next step, how it can be incorporated into PDPs, is discussed could be a way to increase the impact of RPR.

With the small number of RPR participants in atypical practices it is not always feasible to match the reviewers' specialty area with RPR participants. However, it is important to ensure 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.

The reviewers have a key role in RPR

Survey results indicate reviewers were positive about all aspects of the programme:

- Almost all reviewers felt they had the necessary training, support and information about the doctor to be effective reviewers.
- More than half (59%) wanted more reviews. The remainder reported they were completing the right number (41%). About one review per month was ideal for most reviewers. The number of reviews for general practice based reviewers dropped in 2016 because the majority of doctors working in general practice were reviewed in previous years and were not yet eligible for another RPR.

Reviewers were confident their feedback enabled doctors to make changes in their practice and improve care for patients. However, they were uncertain if changes took place because they did not have any follow-up contact with the reviewed doctors.

Strengthening RPR

Developing the reviewers' ability to provide feedback on opportunities to develop the reviewed doctors' practice has been a focus of reviewer training.

Further development for reviewers has the potential to strengthen RPR. Aspects of reviewer development suggested by the evaluation are:

- Confirming the effectiveness of their collegial approach to RPR as a quality improvement process
- Confirming they are effective as reviewers even when the doctor being reviewed has a different scope of practice to their own
- How to provide feedback and advice that would assist RPR doctors to use information from the review to make changes
- How to provide tailored feedback for doctors who are performing at different levels (superior, satisfactory and unsatisfactory).

Reviewers often expressed desire for some follow-up contact with doctors to discuss suggestions for practice improvement. Post-review contact could also provide an opportunity for doctors to provide feedback to the reviewer.

Evaluation next steps

The evaluation will continue to collect data from RPR participants as they receive their reports and 12 months after they receive their reports. Additional completions will facilitate further time-series analysis.

1. Background to Regular Practice Review (RPR)

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

Continuing professional development programmes (CPD) are one of the mechanisms professional organisations use to ensure the competencies of their members are maintained. Council has introduced regular practice review (RPR) as a mandatory requirement of the recertification programme for doctors registered in a general scope of practice, many of whom work in general practice.

1.1 The Regular Practice Review (RPR)[3]

RPR is a quality improvement process. Its primary purpose 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 the identification of poor performance which may adversely affect patient care.

Council implemented RPR through the bpac^{nz} *Inpractice* programme from July 2013. To the end of January 2017, there have been 609 reviews, of which 28 doctors have been reviewed twice. The funding for the RPR component of the *Inpractice* recertification programme comes from the annual fee general registrants pay to be part of the *Inpractice* programme.

The programme design has been developed over the past three years by bpac^{nz} and Council based on evidence from the literature, New Zealand experiences and discussions with stakeholders such as professional organisations. RPR involves:

- **Pre-visit**: The reviewer:
  - reviews professional development e-Portfolio
  - reviews prescribing and laboratory test reports
  - reviews multisource and/or patient feedback
  - has a phone call with the collegial relationship provider
  - has a phone call with the doctor being reviewed.
- **Practice visit**: Interviews with the doctor and in some cases colleagues, observation of consultations, review of records and clinical reasoning

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

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

- **Post-visit**: Report delivered to the doctor and Council summarising findings
- **Post-visit follow-up**: by bpac^{nz} with doctors where areas of concern or non-compliance with requirements were identified through the review.

1.2 Other recertification requirements[4]

In addition to completing an RPR every three years, doctors participating in the *Inpractice* programme must:

- Complete a minimum of 50 hours of activity per year which must include at least:
  - A minimum of 10 hours of peer review
  - A minimum of 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)
- Complete multisource feedback (MSF) every three years
- Have a collegial relationship with a vocationally registered doctor.

1.3 The Collegial Relationship Provider (CRP) [4]

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 collegial relationship provider (CRP) is expected to provide guidance and mentorship for doctors registered in a general scope. Doctors are required to meet with their CRP:

- Six times in the first 12 months of registration in general scope
- Four times per annum in subsequent years.

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

A CRP should be a role model of good medical practice, a sounding board for the doctor and a resource in times of difficulty. It is important to note that the collegial relationship is not a supervisory relationship and colleagues are not required to supervise a doctor's practice.

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

2. The evaluation of RPR

Council commissioned this 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.

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

2.1 The evaluation design

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

2.2 Information sources

This report updates information drawn from interviews and surveys of doctors participating in RPR[5]. Data have been collected from online surveys sent to all reviewed doctors approximately two-weeks after they receive their RPR report. Doctors who complete the survey are asked if they are available to be interviewed. In interviews doctors are asked for the name of their collegial relationship provider (CRP) who is then invited to take part in an interview.

Twelve months after their participation in RPR, doctors who completed the post-RPR survey are sent a follow-up survey. The follow-up survey also includes a request for an interview.

Figure 1 provides a summary of the data sources used for the evaluation of RPR to the end of January 2017. The evaluation started slightly after the introduction of RPR

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

hence the total number of doctors invited to take part in the evaluation is less than the total number of doctors reviewed. There were fewer reviewers in the most recent survey.

Data from:	Doctors	Reviewers
Online surveys	• Post-RPR survey of participating doctors (295 of 445, 66%) • Twelve-months after RPR (133 of 192, 69%)	• 2014 survey (19 of 19, 100%) • 2016 (22 of 30, 73%) • 2017 (17 of 19, 89%)
Interviews	• Post-RPR interviews with participating doctors (58) • Interviews with doctors approximately 12 months after RPR (21)	• 2014 reviewer interviews (6) • 2016 reviewer interviews (9) • 2017 reviewer interviews (5)
	Other sources of data	
bpac^{nz} data	• Patient feedback forms on doctors completed before the RPR visit (12,407) • Colleague feedback for participating doctors completed before the RPR visit (4,348) • RPR report results for all participating doctors (608)	
Other	• A review of the literature about professional development	
	• Interviews with collegial relationship providers (11)	

Figure 1. Information sources for the evaluation from end of January 2017.

2.3 The participating doctors

There were small differences in the profiles of the doctors who completed the post-RPR survey and 12 month survey (Table 1). Doctors completing the surveys were evenly divided between those with fewer than 10 years of practice in New Zealand and those with between 11 and 30 years. A smaller proportion had been practicing for more than 30 years (Table 1). Most of the doctors who had been in practice in New Zealand for fewer than ten years had trained overseas.

Around two-thirds of doctors who responded to the post-RPR and 12 month surveys had completed their training outside New Zealand. English was not the first language for approximately one-quarter of doctors who responded to the post RPR survey.

Table 1. Characteristics of doctors who completed post-RPR and 12 month surveys.

Characteristic	Post-RPR survey (n = 295)	12 month survey (n = 133)
Practicing in New Zealand for: • <10 years • 11-30 years • 30+ years	 45% 43% 13%	 43% 47% 11%
Training location: • New Zealand • UK • South Africa • Asia • North America • Other • Unknown	 34% 24% 9% 7% 5% 12% 8%	 35% 24% 11% 6% 4% 12% 9%
English not first language	24%	20%
Medical branch[6]: • General practice • Other[7]	 59% 41%	 65% 35%

2.4 Strengths and limitations at this stage of the evaluation

The survey response rates (66% Post-RPR survey, 69% 12 month survey) provide confidence that the sample included in the evaluation are broadly representative of all doctors reviewed over the evaluation period. Most demographic data except medical branch are not available to compare responding and non-responding doctors. However, the percentage of doctors working in general practice in both surveys is comparable to the total sample of RPR participants, with a 5% difference in medical branch for the post-RPR survey and 1% difference in medical branch for the 12 month survey (Table 2).

[6] Based on bpac[nz] designations

[7] Other medical branches 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.

Table 2. Comparison of medical branch between total RPR participants and the evaluation survey participants

	Works in general practice	Does not work in general practice
Total RPR participants (n = 608)	64%	36%
Post-RPR survey (n = 295)	59%	41%
12 month survey (n = 133)	65%	35%

Doctors who completed both the post-RPR and the 12 month survey were slightly more likely to be doctors working in general practice. Comparisons between the post-RPR and 12 month survey responses are based only on doctors who completed both surveys.

The evaluation findings are based on the reviewed doctors' self-reported changes to practice. We have no way of validating whether actual changes have been made to practice. However, more objective information about the extent changes have been made will be available when ratings can be compared between the first and second times doctors participate in RPR.

The overall trends and relationships found in this report have been consistent with previous reports, where there has been change it is noted in the text.

3. RPR ratings

Key points

Most doctors received high ratings from their RPR reviewer, colleagues and patients. Approximately half of the reviewed doctors received superior ratings for each of the review areas. Almost all others achieved satisfactory ratings. Most unsatisfactory ratings were about the quality of note keeping or use of patient management system, although numbers were low.

Data collected by bpac^{nz} as part of the review process were analysed to examine the overall distribution of doctors' ratings.

When the report ratings overall were considered, 51% percent of all reviewed doctors that data was available for were rated as superior (had an average rating of over seven) and 48% were rated as satisfactory (had an average rating of between four and six) (Table 3).

Table 3. Average percentage of doctors in each RPR rating category (1-3 = unsatisfactory, 4-6 = satisfactory, 7-9 = superior) (~0 indicates less than 0.5%)

	Unsatisfactory	Satisfactory	Superior
Records/requirements (n = 551)	2%	53%	45%
Doctor/patient relationship (n = 543)	<0.5%	39%	60%
Clinical reasoning (n = 542)	<0.5%	48%	52%
Clinical practice (n = 538)	<0.5%	52%	48%
Total	<0.5%	**48%**	**51%**

When each of the four categories assessed were considered separately, substantial proportions of doctors received a 'superior' rating (Table 4).

Table 4. Average percentage of doctors in each RPR score category (n = 526-550)

	Unsatisfactory	Satisfactory			Superior
RPR rating scores	**1 - 3**	**4**	**5**	**6**	**7 - 9**
Records/requirements					
Ability to competently navigate and use PMS	0.8%	2%	9%	31%	58%
Notes facilitate continuity of care	2.4%	4%	10%	28%	57%
Records show appropriate standard of care	2.5%	4%	10%	28%	56%
Record is clear, accurate, has required information	2.2%	3%	10%	28%	56%
Doctor/patient relationship					
Engaging the patient	0.2%	1%	6%	24%	69%
Responding to the patient	0.0%	1%	7%	24%	68%
Listening to patient	0.2%	1%	7%	27%	65%
Clinical reasoning					
Clinical reasoning for their management	0.4%	2%	8%	27%	62%
Clinical reasoning for investigation	0.4%	2%	10%	30%	57%
Clinical reasoning for diagnosis	0.4%	2%	10%	31%	56%
Clinical practice					
Clinical practice management	0.2%	2%	8%	27%	62%
Clinical practice history	0.0%	1%	12%	30%	56%
Clinical practice examination	0.2%	2%	14%	30%	54%

Analysis of the colleague and patient feedback data found doctors received high ratings for all assessed aspects of their care (

Table 5 and Table 6).

Table 5. Average percentage of doctors in each colleague feedback rating category (1 = worst, 5 = best) (n=398)

	1 - 3	3.01 - 4	4.01 - 4.5	4.51 - 5
Clinical reasoning	0	3%	24%	74%
Clinical practice	0	2%	24%	75%
Communication	0	4%	26%	70%
Trust	0	0	5%	95%
Personal	0	1%	14%	85%
Total	**0**	**2%**	**19%**	**80%**

Table 6. Average percentage of doctors in each patient feedback rating category (1 = worst, 5 = best)

	1-3	3.01-4	4.01-4.5	4.51-5
Manner (n = 326)	0	2%	3%	95%
Providing care (n = 326)	0	2%	5%	94%
Patient involvement (n = 325)	0	2%	7%	90%
Trust (n = 326)	0	1%	7%	92%
Total	**0**	**2%**	**6%**	**93%**

4. Doctors' overall views of RPR

Key points

Before participating, approximately one-third of doctors expected RPR to be useful. Some doctors were concerned the review would be a 'tick-box' exercise, were nervous about being assessed, were not sure what to expect and/or felt they had no need for a review.

Many doctors found participating in RPR a more positive experience than anticipated. Nearly three-quarters (71%) agreed it was a positive experience, 67% found the RPR report useful and more than half (57%) would positively recommend a review to colleagues.

Doctors said they changed their opinions about RPR because it provided reassurance about their practice, they valued the opportunity to have an objective perspective on their practice from a senior colleague, and/or they learned about new development opportunities.

RPR report ratings did not appear to influence whether a doctor would positively recommend RPR to colleagues or not.

4.1 Expectations of RPR before participating

Doctors held mixed views on the usefulness of RPR before they participated. Approximately one-third (32%) thought RPR would be useful (Figure 2). Two-fifths (39%) were neutral, suggesting they may not have known enough about RPR to form a view. Doctors working in general practice were slightly more likely than doctors in other scopes of practice to think the RPR would be useful.

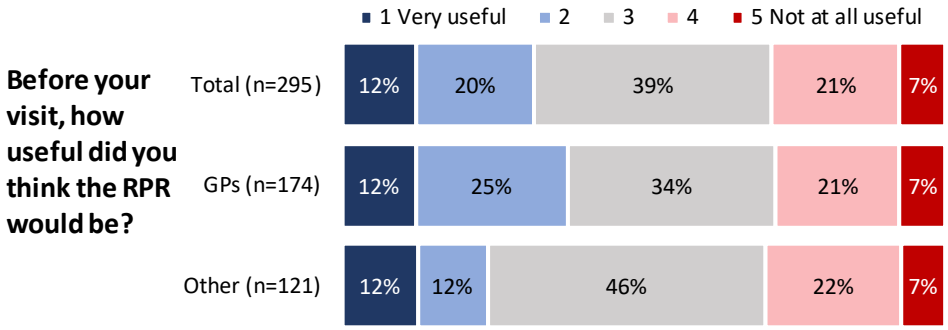


Figure 2. How useful participating doctors thought the RPR visit would be (Post-RPR survey, n = 295).

In the post-RPR survey doctors were asked to explain their expectations about RPR (Table 7). Many of those who thought RPR would be useful expected to get *"at least*

something" out of the review. The doctors who did not expect RPR to be useful commonly explained it was because they thought the review would be a *"tick-box"* exercise, were nervous about being assessed, were not sure what to expect and/or felt they had no need for a review.

Table 7. Reasons why participating doctors did not expect RPR to be useful (Post-RPR survey, n = 295).

Expectations of RPR	Percentage who spoke about it
Expected to get (at least some) useful feedback	19%
Viewed as a tick-box exercise	12%
Nervous about what to expect / being assessed / being observed	11%
Did not expect it to be a useful experience	9%
Unsure what to expect beforehand	7%
Keep self up to date (e.g. internal quality improvement programme)	6%
Expected emphasis would be on criticising practice	4%

In earlier evaluation reports, we suggested that as RPR becomes better known the positive experiences of participating doctors may lead to an increase in the number who expect RPR to be useful. However, the proportion of doctors expecting RPR to be useful before participation has not increased past 2014-15 levels (see Figure 4). As doctors start to participate in their second review we will monitor their expectations and compare them with their expectations of their first review.

4.2 Participating doctors' opinions after completing RPR

Doctors were more positive about RPR after their review. Nearly three-quarters (71%) agreed it was a positive experience, 67% found the RPR report useful and more than half (57%) would positively recommend RPR to colleagues (Figure 3).

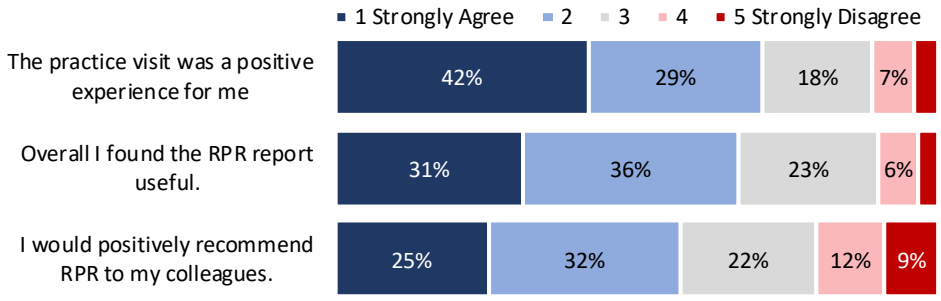


Figure 3. Participating doctors' overall experience of RPR (Post-RPR survey, n = 295).

The proportion who would recommend a review to their colleagues has remained fairly constant with a slight decrease in the latest half year (Figure 4).

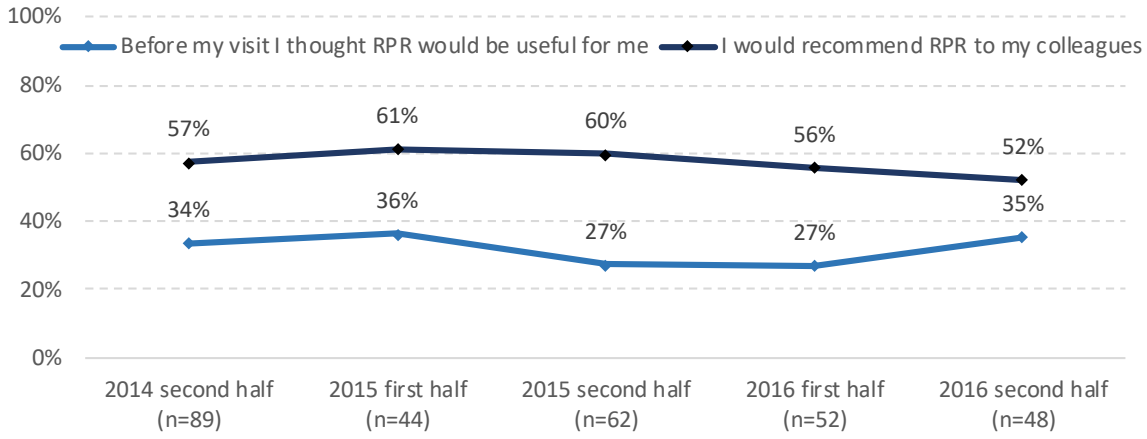


Figure 4. Participating doctors' views on RPR over time (not including first half 2014) (Post-RPR survey, n = 295).

Doctors said they changed their opinions about RPR because it provided reassurance about their practice, they valued the opportunity to have an objective perspective on their practice from a senior colleague, and/or they learned about new development opportunities (Table 8).

Table 8. Reasons why participating doctors found their RPR useful (Post-RPR survey, n = 295).

Reasons why RPR was useful		Percentage who spoke about it
Personal knowledge	To know where you stand in relation to other doctors, provides proof of competency (to self and others) which can increase confidence in skills	28%
	Opportunity for self assessment / self reflection and gain insight on practice	9%
Feedback	Opportunity to get advice / have a discussion with a senior colleague or peer	26%
	Get an objective perspective on how they practice	16%
	Positive to get feedback from someone who has actually observed practice	10%
Strengths and opportunities	Have areas for improvement highlighted	24%
	Have strengths highlighted	18%

Overall, RPR ratings were not associated with whether doctors said they would recommend RPR to a colleague (Table 9).

Table 9. The proportion of doctors with average superior ratings (seven or above) in each category who strongly agree or agree they would or would not positively recommend RPR (bpac^{nz} and Post-RPR survey data).

	Proportion with an average superior rating (7-9) for each category			
	Records/ requirements	**Dr patient relationship**	**Clinical reasoning**	**Clinical practice**
Would positively recommend RPR (n = 156-160)	51%	61%	52%	48%
Neutral or would not recommend RPR (n = 114-118)	46%	61%	56%	53%

5. Changes following participation in RPR

Key points

After RPR, nearly half (46%) of doctors said they had made changes to their practice due to their review. A further 13% intended to make changes in the future.

The reviews did not suggest changes for all doctors. Doctors with high RPR ratings were generally less likely to receive feedback about new opportunities for development and less likely to make changes.

There was a small decrease in the proportion of doctors who reported changes to practice 12 months after RPR compared to shortly after RPR (42% compared to 51%). The information suggests changes made in response to RPR were maintained for many doctors.

Doctors who reported making changes to their practice 12 months after RPR were more likely than those who had not made changes to:

- Have learned new opportunities for development
- Have made changes to their PDP
- Agree their RPR report was accurate
- Be positive about their reviewer
- Recommend RPR to colleagues.

Post-RPR, around half of the responding doctors planned to adjust their PDP based on their review. They were more likely to adjust their PDPs to target new opportunities for development than to build on strengths. Approximately half (49%) of the doctors who responded to the post-RPR survey had already made changes to their PDPs as a result of their participation in RPR. Twelve months later, smaller proportions (49% post-RPR survey compared to 31% at 12 month survey) reported changes.

Just under half of doctors expected changes made following their review to contribute to improvements in the care they deliver to their patients (45%) and/or had improved their practice in other ways (53%).

Accumulated evidence suggests commonly used continuing medical education (CME) methods such as conferences can be ineffective in changing doctors' professional practice (Davis 1995). An analysis of systematic reviews by Bloom 2005 found changing practice was possible. Interactive techniques were the most effective way to change physician care, including approaches such as audit/feedback, academic detailing/outreach and reminders. O'Brien (2007) provides an example of how

educational outreach visits were used to create sustainable and small but potentially important changes in prescribing habits.

5.1 Changes in practice

This section examines the post-RPR changes reported by doctors participating in RPR and whether those changes were maintained 12 months later[8].

5.1.1. Two-weeks after RPR

In the post-RPR survey, nearly half (46%) of responding doctors said they had already made changes to their practice as a result of RPR and a further 13% intended to make changes (Figure 5).

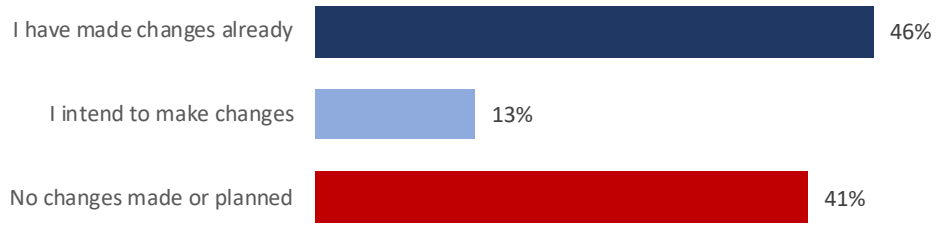


Figure 5. Proportion of participating doctors who said they had made changes, intended or did not intend to make changes (Post-RPR survey, n = 295).

The proportion of doctors who reported changes in practice as a result of RPR has varied over time and by practice type (Figure 6). Doctors working in general practice have been consistently more likely to make changes to their practice than doctors in other practice settings.

[8] Post-RPR results when not compared with 12 month results are reported for all doctors who participated in the evaluation (n = 295). When comparing 12 month survey results with post-RPR, results are reported for doctors who completed both the post-RPR and 12 month surveys (n = 133).

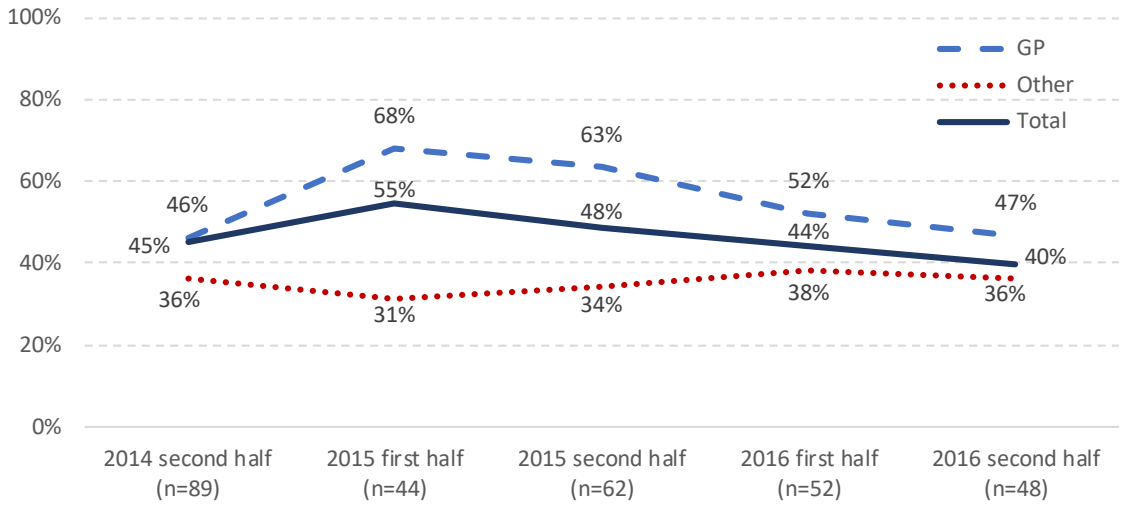


Figure 6. Proportion of post-RPR participating doctors who had made changes to practice showing the calendar half year the post-RPR survey was completed (Post-RPR survey, total n = 295, Working in general practice n = 174, Not working in general practice n = 121)

Doctors who received superior ratings in clinical reasoning and clinical practice in their RPR reports were less likely to have reported making changes to practice (Table 10).

Table 10. The proportion of doctors with superior ratings (seven or above) in each category who in RPR who had made changes to their practice (Significant differences are in bold) (bpac^{nz} and Post-RPR survey data).

	Proportion with an average rating of superior (7-9) for each category			
	Records/ requirements	**Dr patient relationship**	**Clinical reasoning**	**Clinical practice**
Made changes to practice (n = 126-130)	49%	57%	48%	**41%**
No changes to practice (n = 145-148)	48%	64%	59%	**58%**

The changes doctors said they made to their practice included changes to consultation management and style, patient care and administration (Table 11). The percentages in the table represent doctors who volunteered this information in response to an open-ended question about changes they had made.

Table 11. Changes participating doctors' have made as a result of RPR (Post-RPR survey, n = 295)

Area of change		Percentage who spoke about it	Example
Consultation	Changed how consult is managed	15%	*Tried to change consultation style, trying to prioritise patient questions.*
	Communicating more effectively	13%	*Changed how I word questions to patients. Better use of silence.*
Patient care	Improved notes and record keeping	15%	*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	7%	*[I] have made changes to my prescribing methods and there is a new awareness of having to constantly check current guidelines.*
	Reviewed tests ordered	2%	
Administration	E-management	5%	*I've made a lot more use of, our IT person helped, the bpac embedded in medtech.*
	Audit	4%	*Starting audit my clinic record and make a protocol to avoid the chance of missing document.*
Other	Unspecified or technical change	7%	*[Changes were] some specific things about airway management.*
	Self-care	3%	*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*

5.1.2. Impact of changes to practice

Although there is evidence about how to influence changes in practice, Bloom 2005 and Boonyasai 2007 report the difficulty of measuring the impact of initiatives similar to RPR on patient outcomes. The impacts of changes in practice on patient care are complex and hard to quantify, particularly where the intervention takes a broad approach. Additional studies are needed to determine whether educational interventions create clinical benefits (Boonyasai 2007).

In the RPR survey and interviews, doctors often reported they had made small changes in response to RPR. Small improvements are relatively easy for doctors to make with minimal ongoing support and may therefore be more likely to be made and also sustained compared to more substantive changes. Although changes were often described as *"small"* they have the potential to make real differences in all areas of practice.

5.1.3. Twelve months later: maintenance of changes to practice

We examined the extent changes were maintained by comparing the doctors who by the end of July had completed both the post-RPR survey and the survey 12 months

later. Twelve months after participating in RPR, the proportion of doctors reporting they had made changes to their practice after their review decreased from 51% to 42% (Figure 7).

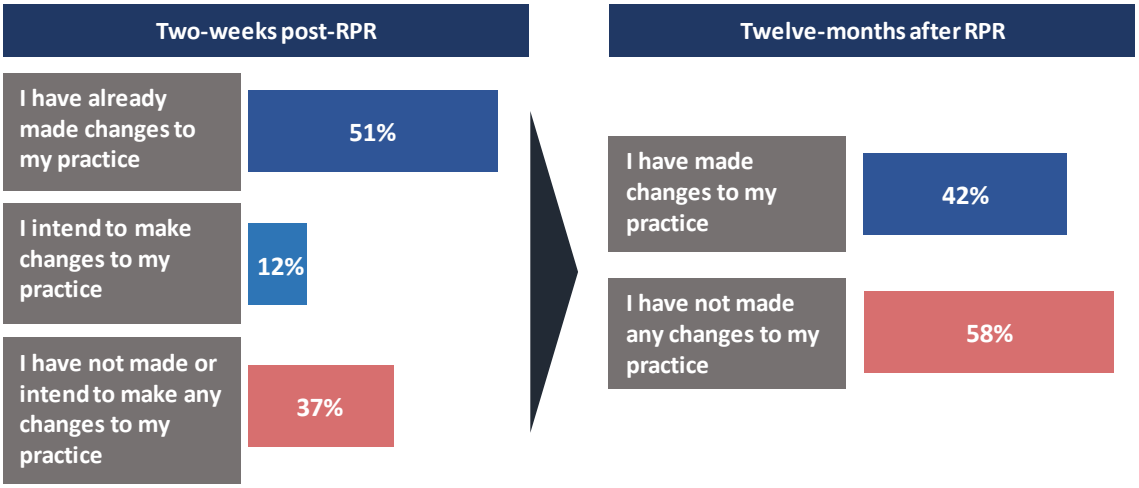


Figure 7. Proportion of participating doctors who had made changes to their practice (Post-RPR and 12 month survey, n = 133)

Many doctors gave consistent answers in both surveys (for example, saying that they had made changes to practice both post-RPR and 12 months later) (Figure 8). The doctors who reported post-RPR they had made changes to practice but not 12 months later had a similar profile to the doctors who reported making changes in both surveys. Potential explanations are:

- Doctors forgot they made changes, or felt they were small and not worthwhile mentioning a year later
- Changes became business as usual
- The change was a one-time event (e.g. going to a workshop or seminar)
- Doctors made a change but then reverted back to their previous practice.

The likelihood that some doctors forgot the changes they had made is supported by interviews with five of the 25 doctors who reported practice changes post-RPR but not at 12 months. Although they reported making no changes in the 12 month survey, during the interviews at 12 months all doctors discussed changes they had made and maintained after their review. One doctor spoke about how some changes had been maintained while for others they had reverted to their usual practice as it worked better for him and his patients.

> *Yes, absolutely, I changed a few things in my consultation style. So that was a lot about how I changed how I wrap up and finish the consultation in a timely way…. I have also made changes in my testing.*
>
> *So, it was changes to practice management by telling patients what we're going to cover and trying to improve my time management.*

So, there were a few changes but a lot of it went back to the things that actually work for the patients we have here.

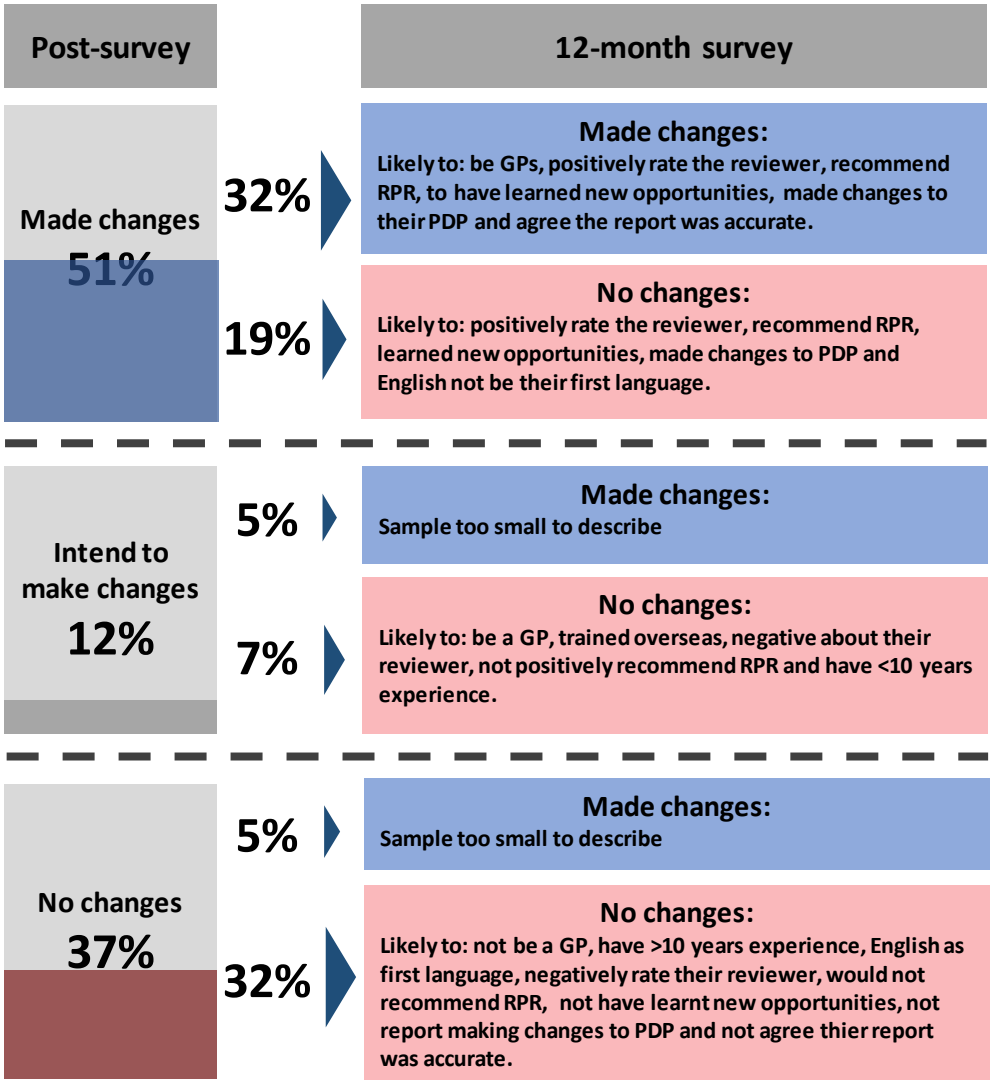


Figure 8. Changes to practice due to RPR over time (Post-RPR and 12 month survey, n = 133)

The characteristics of doctors belonging to these different groups in Figure 8 were compared (Table 12). Where characteristics are over-represented in a group, they are shaded dark blue and where they are under-represented they are light coloured.

Table 12. Prevalence of different doctor views and the sustainability of changes to practice (bold dark blue indicates ≥ 10% more than total sample, bold light blue indicates ≥ 10% fewer than total sample (Post-RPR and 12 month survey, n = 133)[9].

Characteristics	Proportion overall (n = 133)	Stable - changes made (n = 43)	Moved - from changes to no changes (n = 25)	Stable - no changes (n = 43)
Working in general practice	65%	**77%**	72%	**49%**
Practiced for < 10 years	43%	49%	52%	**28%**
NZ trained	35%	30%	32%	40%
English not first language	20%	21%	**48%**	**9%**
Positive about reviewer	79%	**95%**	**92%**	**58%**
Positively recommend RPR	62%	**91%**	**72%**	**33%**
Learned new opportunities	53%	**84%**	**64%**	**14%**
Have made changes to PDP	51%	**81%**	**80%**	**14%**
Agree report was accurate	71%	**86%**	72%	**56%**

The differences between groups in the RPR evaluation reflect findings in the literature about factors that are important in supporting practice change:

- Respecting the skills of the reviewer
- Identifying opportunities for development
- Capturing development opportunities in professional development plans.

These three aspects of RPR are also linked to doctors' comments about their expectations of RPR and why they found their reviews useful.

Making changes to PDPs was associated with making changes to practice and supports the theory that PDPs form a connection between learning of opportunities for development and making changes to practice.

5.2 Changes to professional development

In general, CPD is valued and seen as effective when it addresses the needs of individual clinicians, and the context in which they work (Hays 2002 and Schostak 2010). One of the aims of RPR is to improve the way doctors engage with professional development activities and planning. As the evaluation progresses, comparison between doctors' first and subsequent RPR ratings will provide a more objective measure of changes.

[9] This table only includes groups with more than ten doctors.

5.2.1. Post-RPR changes to professional development

Half of the doctors planned to make changes to their PDP following their review (Figure 9). Doctors were more likely to agree they would change their PDPs to target opportunities for development than to maintain areas of strength.

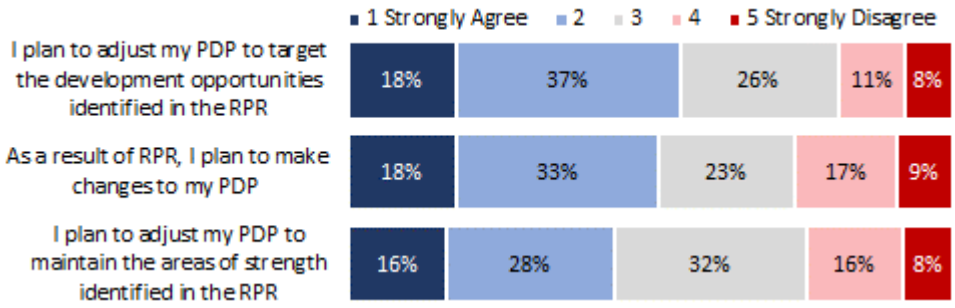


Figure 9. Doctors' changes to their professional development plans (Post-RPR survey, n = 295).

In the post-RPR survey, half (49%) of doctors reported making changes to their PDP. Close to one-third (32%) of those who had had not made PDP changes said they still planned to make them in the future as a result of their RPR.

RPR data from bpac^{nz} were compared to the changes to PDPs reported by doctors. With the exception of the records/requirement category, doctors who received 'superior' ratings were significantly less likely to have made changes to their PDP (Table 13).

Table 13. Percentage of doctors who received an average rating of superior (seven or above) in each category in RPR for those who did and did not make changes to their PDP (Significant differences are in bold) (bpac^{nz} and Post-RPR survey data).

	Proportion with an average superior rating (7-9) for each category			
	Records/ requirements	**Dr patient relationship**	**Clinical reasoning**	**Clinical practice**
Made changes to PDP (n = 136-138)	46%	**51%**	**46%**	**40%**
No changes to PDP (n = 136-140)	51%	**70%**	**61%**	**60%**

5.2.2. Twelve months later: changes to professional development

Twelve months later, fewer doctors reported making changes to their PDP (31%) compared to the post-RPR survey (49%) (Figure 10). At 12 months, one-fifth of doctors reported they had changed how they managed their PDP and one-quarter had changed their PDP to make it more useful.

The lower proportion reporting changes to PDP could be for similar reasons as the decrease in changes in practice (forgot they made changes, changes were too small to mention, changes were one-time events and doctors made changes but reverted back).

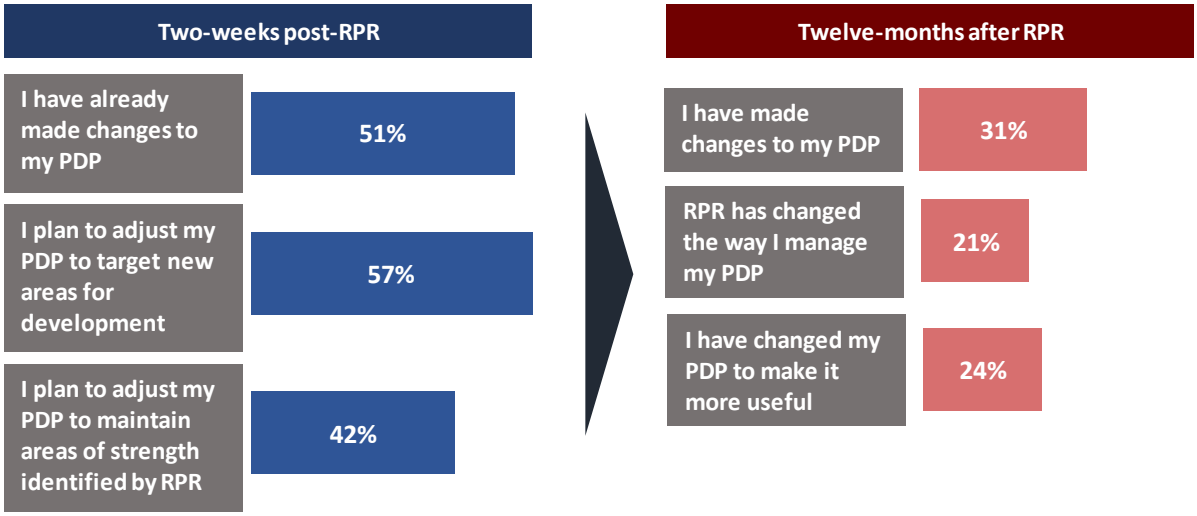


Figure 10. Comparing the views of the 12 month survey cohort on changes to professional development plans post-RPR and after 12 months (n = 133).

5.2.3. Examples of changes to professional development

Examples of changes doctors made to their PDPs are summarised in Table 14.

Table 14. Examples of changes to professional development

Change to PDP	Example
Improving management of professional development, such as updating regularly.	*I've changed the way I document my CME in the bpac^{nz} system; PDP is set first, then followed by the appropriate CME.*
Improving the quality of PDP and goals	*Created a real PDP!* *We talked about making my goals SMART goals. I have already put one into my PDP that I will do every year.*
Fine tuning PDP activities	*More study and build up experience on paediatric infectious disease.* *Some of the basic background knowledge is a bit rusty. I'll just hit the books a bit more and keeping abreast of the journals*

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].*
Entering further training	*I have joined the GP registrar training programme.*
Self-audit activities	*I researched note keeping and then I did an audit of my notes keeping.* *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.*

5.3 Changes to quality of care

RPR aims to improve outcomes for patients by improving the quality of care they receive. It is difficult to assess the impact of changes to practice on patient outcomes. However, difficulty in measuring the impact of changes does not mean the examined initiatives do not improve the care for patients. Ivers 2012, discusses the significance of small changes, reporting that audit and feedback can lead to small but potentially important improvements in practice for doctors.

In the RPR evaluation, potential improvements in outcomes for patients are assessed by considering the types of changes to practice and professional development reported by doctors. Changes aligned with improvements in 'best practice' suggest the potential for improved outcomes for patients.

In response to the post-RPR survey, approximately half (45%) of doctors thought that participating in RPR improved the care they deliver to their patients and/or helped in other ways (53%) (Figure 11). Close to one-quarter disagreed that RPR had improved the care they delivered to their patients or helped improve their practice in other ways.

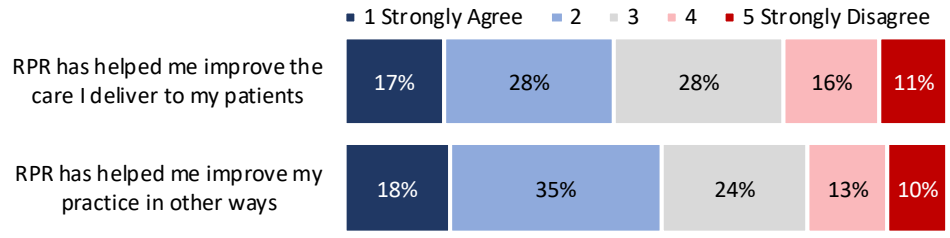


Figure 11. Doctors' views on the impact of the RPR (Post-RPR survey, n = 295).

Below is a brief case study outlining the positive experience of a doctor and why RPR worked so well for them. In this and the other case studies throughout the report names and certain details have been changed for confidentiality.

Dr A – participated in two RPR reviews and positive about both

Dr A 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 RPR three years ago, Dr A 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.*

The reasons why the first RPR was so good was the reviewer suggested changes to help improve Dr A's 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 small things.

> *So now I have a format for histories that I go through in my head and I check off each thing, it's been really good.*
>
> *I have also audited myself on that to make sure I'm staying on doing it well… I didn't know how to audit but now I do and it's great.*

Dr A liked the way the reviewer from the second RPR (not the same as the first) commented on the changes she had implemented after the first RPR and that the latest reviewer also had suggestions to improve her practice and PDP.

As well as suggestions for changing practice and PDP, Dr A also appreciated the RPR addressed personal care and since the first RPR has dropped her hours.

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

Dr A found the RPR was collegial, accurate and covered her whole practice.

> *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.*

Dr A thought there should be something like the RPR for all doctors.

> *Its suits me, I like it, I think every doctor should have something… I would think no matter how highly qualified they are 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.*

Dr A appreciated the reviewer speaking to her CRP on the day to get a wider impression of how she practised.

Considerations from Dr A's feedback

- Having a positive RPR experience can reduce anxiety for future RPRs.
- Receiving useful/useable feedback can help RPRs to be seen as more worthwhile.
- A second RPR can be an opportunity for following up on progress in response to previous suggestions.
- Reviewing self-care is appreciated by some doctors.

6. What can influence a doctor's response to RPR

Key points

Doctors' backgrounds, characteristics, personal views and experiences can influence their response to RPR.

Doctors' characteristics influenced their likelihood of making changes to practice and PDPs as a result of their participation in RPR. Doctors were more likely to make changes to practice if they:

- Were doctors working in general practice
- Did not speak English as a first language.

A minority of doctors did not acknowledge the value of a review. Some considered they were sufficiently experienced or adequately supervised/ reviewed and would not benefit from the RPR. Some considered their selection for a review was unfair and believed all doctors should be treated the same.

Certain experiences of RPR were associated with increased likelihood of making changes to practice and professional development plans. Doctors were more likely to make changes if they:

- Agreed reviewers had the appropriate skills to review them
- Would positively recommend RPR
- Learned new opportunities for development
- Agreed their report was accurate.

While some factors influencing responses to RPR cannot be changed, there is the potential to adapt the RPR process to influence doctors' experiences.

6.1 Characteristics of the participating doctors

Doctors' backgrounds, characteristics and personal views and experiences can influence their response to RPR. When completing the post-RPR survey, doctors recorded their:

- Years in practice
- Whether English was their first language
- Where they trained
- Their area of practice.

In interviews with doctors the evaluation team explored other characteristics influencing doctors' responses to RPR.

6.1.1. Background

Doctors who did not speak English as a first language were more likely to have made changes to their practice and PDP (Table 15).

Table 15. The influence of demographic factors on doctors' responses to RPR (Post-RPR survey, n=295) (Statistically significantly differences are in bold)

	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	224	105 (47%)	**92 (41%)**	121 (54%)
English as a second language	71	41 (58%)	**44 (62%)**	48 (68%)
Less than 10 years in practice in NZ	131	66 (50%)	65 (50%)	81 (62%)
11-30 years in practice in NZ	126	61 (48%)	55 (44%)	65 (52%)
30+ years in practice in NZ	37	19 (51%)	15 (41%)	22 (59%)
Trained in NZ	101	51 (50%)	42 (42%)	52 (51%)
Trained elsewhere	194	95 (49%)	94 (48%)	117 (60%)

6.2 Doctors' personal views about reviews

Doctors' understanding of RPR influences their expectations of the programme. Their expectations may be influenced by their personal views on the following:

- **Relevance of RPR programme for themselves.** Some doctors see themselves as already highly competent and see no need to be reviewed. Some consider they work in settings where peer review is readily available. Others see the need for the programme and think it will be useful.

  So it is a good idea for people practicing but I'm not [practicing] so it didn't fit.

- **Equity of RPR selection**. Some consider it is unfair vocationally registered doctors are not part of RPR and either think non-vocationally registered doctors should be excluded or that all doctors should be reviewed.

- **The cost (time and financial) of RPR compared to the perceived benefit.** Doctors either thought it 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 up 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.

- **Practice visit is appropriate.** Views on the practice visit varied. Most doctors considered the practice visit was the only way to objectively assess how a doctor is practicing whilst others thought it was unnecessary and a review could be based on notes and a phone call.

  It's very important to get an objective overview of how you are going. I am sure some people could be a little intimidated by the visit but I think it's a very good idea.

  What I think would be better would be to have a phone call every year. A personalised phone call checking up on what I'm doing and what are the issues etc., because the RPR is such a big deal you know.

While doctors held divergent views, those who fundamentally disagreed with the concept of a review were less likely to find RPR useful compared to those who supported reviews.

The RPR programme has some opportunity to influence doctors' personal views through the communication sent to doctors selected to participate in RPR. For example, emphasising RPR's focus on quality improvement may improve doctors' outlook before they participate.

A brief case story illustrating how a doctor's characteristics and personal views influence RPR and its outcomes is outlined below.

Dr B – negative about RPR and made no changes

Dr B is a doctor with over 30 years' experience and is vocationally registered overseas, although his vocational training is 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 their RPR, that they were already a senior doctor with a good record and should not need to be checked.

Dr B thought RPR was unnecessary because in his non-general practice environment doctors constantly collaborate with other professionals, and concerns about competency would come up naturally. Dr B felt RPR was more suited for doctors who practice in isolation.

Dr B found RPR was resource intensive and organising and participating in it was somewhat *"anxiety inducing"*. They did not think getting patient feedback would be valid in their practice setting due to low response rates and especially the

short-term nature of care. Dr B also felt embarrassed asking patients to fill in the feedback forms. The doctor felt getting feedback from colleagues would not yield anything that would not come to light without the review.

Dr B also had some negative experiences with the practice visit itself. He considered the reviewer to be their junior as the reviewer only had some experience in Dr B's speciality whilst Dr B had many years' experience and had previously worked as a consultant. Although Dr B found RPR unhelpful, the doctor commented that the reviewer did as good a job as could be done, considering the circumstances and the experience was pleasant and collegial.

Dr B thought the questions asked during the RPR were not well suited to his area of practice. Another problem outlined by Dr B was very few patients attended on the day of the review so the review was predominantly based on case reviews, which Dr B thought could have been done over the phone.

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 their RPR.

Dr B's feedback highlights the importance of communicating the purpose and reason for RPR and the current process. For example, reframing the patient feedback as a way to work on making consultations as positive as possible for patients rather than a reflection on the doctor.

Considerations from Dr B's feedback

Initial view of RPR: Although not much can be done to change doctors' opinions on the idea of the RPR, other smaller changes may improve the experience.

Reviewer match: Dr B saw the reviewer as his junior. This could be remedied by having a more experienced reviewer or by explaining the reviewer's experience as a reviewer and the generic nature of some aspects of a review. There has been an increased focus on improved matching between participants and reviewers since Dr B was included in the evaluation but this issue continues to be raised by other doctors.

Match between RPR process and area of practice: RPR was seen to be designed for general practice. The questions and report could be adapted to be more suited to other areas of practice. Increased flexibility about the review process may be required to meet the needs of doctors who are not working in general practice.

Reviewer feedback and suggestions about how to improve their practice are very important to participants. There may be generic information that could be helpful

for example, about the evidence supporting effective approaches to professional development that could be developed and provided to participants as well as personalised feedback.

6.3 Doctors' professional context

6.3.1. Type of practice

Just under three-fifths of doctors (59%) who have participated in Post-RPR survey work in general practice settings (Table 16). While often similar in some ways, general practices can vary in characteristics such as 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 practice than doctors working in other settings such as hospitals or clinics specialising in an area of health. Compared to one in 20 doctors working in general practice, close to one in six doctors not working in general practice considered RPR did not fit with them and their practice in some way.

Table 16. Influence of the practice setting (Post-RPR survey, n = 295) (Statistically significant differences are in bold)

	Number of doctors	Have made changes to PDP	Have made changes to practice	Would recommend RPR to colleagues
Working in general practice	174	94 (54%)	**93 (53%)**	106 (61%)
Not working in general practice	121	52 (43%)	**43 (36%)**	63 (52%)

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. This view was closely linked to seeing RPR as a tool for identifying doctors practicing unsafely rather than a tool for ongoing quality improvement.

A number of doctors in hospitals where they are all working together, then they are having regular reviews with each other all the time as they work on the same patients, so it might not be as valuable for them.

The variety of practices and circumstances highlights the importance of flexibility in the RPR process and for the reviewer to adjust the process to suit the participating doctor. For example, this could include going to multiple locations over the day, waiving the patient feedback requirement and/or adapting the questions asked during the RPR. Currently the RPR process has been adapted for some medical branches which are not general practice, and for the areas that it has not been adapted for there is flexibility for the reviewer to ignore certain sections. Some doctors appreciated this level of flexibility but others thought it did not go far enough.

> *The first reviewer I had he put lines through some sections of the report and wrote other comments and noted that this section doesn't match this model. So the forms for people who are a little more rigid in their thinking, the forms need to give them the option for something else.*

A very small number of doctors raised concerns about the effect of the practice visit on their patients. Issues related to obtaining consent from the patient for the reviewer to observe a consultation and perceived risks to patient wellbeing associated with the reviewer observing a consultation.

> *I don't like them [the reviews]. It infringes on a doctor's doctor-patient relationship.*

Below is a summary of how one doctor's type of practice influenced how they viewed their RPR.

Dr C – Likes idea of RPR but more suited for doctors working in isolation

Dr C trained and has worked in New Zealand for more than 20 years. She has completed postgraduate qualifications in her specialty but does not belong to a college.

Prior to her current role, Dr C worked in relative isolation and relished the chance to be reviewed by peers and felt it was an important way to continue practicing safely. Dr C also thought RPRs could be helpful even for doctors who are in colleges, as it is more important to support doctors who work in isolation 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.

However, Dr C currently works in a large multidisciplinary team surrounded by others in her speciality and believes she is reviewed continuously in her regular working life and RPR would not add anything.

Dr C did not find the RPR visit stressful but did find organising the time to do it very onerous due to a full schedule. Dr C's patients had specific characteristics

that made gathering patient feedback difficult and time consuming. She did not think the RPR process was appropriate for her type of practice.

It was stressful in terms of having to find the time but it was not stressful in terms of having the visit or interacting with the reviewer. I've got no concerns, but that's because I'm confident in myself and am regularly peer reviewed.

Dr C felt her concerns were confirmed after the practice visit as she found she did not learn from the experience. RPR did not identify any areas for further development and she was already aware of the strengths highlighted by the review. Dr C did not create any e-portfolio goals following RPR.

Although Dr C believes RPR is good in theory she concluded it does not suit all doctors or practice types.

Considerations from Dr C's feedback

How isolated someone is in their practice influences their opinions about the need for RPR. Doctors who are regularly reviewed and who do not work in isolation may not see the need for additional review/supervision.

When a doctor has a non-standard patient population, patient feedback may be more difficult to obtain. Flexibility in considering ways to obtain feedback may be required, such as reducing the numbers of patients from whom feedback is sought.

6.4 Experiences of the review process

The experience of the practice visit is the most important part of RPR for doctors as it is the part of the process with the highest cost and the greatest potential benefit. Aspects of the practice visit which can influence doctors' experiences include how easy the visit is to organise, the availability of patients, how well RPR fits into their practice, whether they considered the day of the practice visit represented their practice and their opinion of the reviewer.

6.4.1. Logistics and organisation

Most doctors were positive about the communication and organisation of their review. The majority either had no comment or found RPR easy to organise.

> *The phone call people, bpac^{nz}, are really helpful. When I rang up and I was nervous, they couldn't be more helpful and they, as a person doing it first time round, they facilitate it and make it clearer. They're great, very clear and you can ring them with any questions.*

However, a small number of doctors found RPR disruptive to their practice and difficult to schedule. Some doctors mentioned it was sometimes difficult to arrange

a time that suited both the reviewer and themselves but most understood the struggle of being busy.

> *Because of the setting I work I'm finding it really difficult to get it [the patient feedback] done in the timeframe required, so I'm getting endless emails saying I've only submitted this and it's not done yet… But I certainly understand the requirements its more making it practical in my workplace is the problem I'm having.*

Many doctors valued speaking directly to their reviewer to discuss plans for the day and any accommodations or changes to the usual RPR process their practice required.

> *I really encourage that initial phone call from the reviewer, I found that really helpful to engage with a person. It felt much more comfortable and more friendly and if something had occurred to me I would have been able to ask about it.*

6.4.2. Practice visit

Post-RPR survey respondents were generally positive about the practice visit with only a small proportion disagreeing the practice visit was a positive experience (Figure 12).

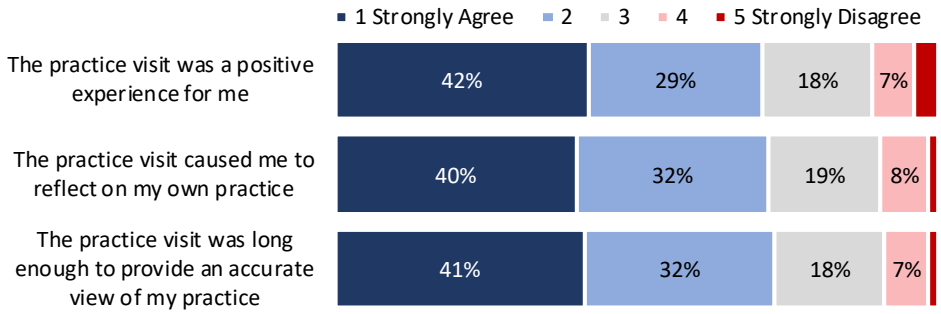


Figure 12. Doctors' views on their experience of the RPR practice visit (Post-RPR survey, n = 295).

Many doctors saw RPR as a form of assessment and felt anxious about the practice visit. Afterwards, most felt their anxiety was unfounded and reported they would be less worried in the future. This change generally arose from the collegial interaction and understanding RPR's focus is on quality improvement. Pre-visit anxiety is likely to be lower for subsequent reviews as doctors are familiar with the process. However, some doctors said they would always feel some nerves before practice visits.

> *It was the first time, I was anxious, but [the reviewer] was so friendly his positive attitude was a relief.*

> *Not as painful as I thought, a much more useful process than I expected. Thank you to all.*

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

Doctors' feedback highlighted the importance of the practice visit as a quality improvement tool to prompt self-reflection. Receiving an objective view about their practice enabled self-reflection that was beneficial. The opportunity to have this objective view often drove doctors' overall opinions of RPR.

> *I think it can be very difficult for colleagues to say "I don't think you're doing this very well, or you could be doing this better" that sort of thing. So [the reviewer] can be honest which is valuable.*

The following case story describes how and why the practice visit for a particular doctor changed their opinion of RPR from a negative to a positive experience.

Dr D – Changed from negative to positive

Dr D completed his medical training in New Zealand 34 years ago and currently works outside general practice in a small niche area of medicine.

Before his review, Dr D had a very poor impression of RPR. He knew it was important because there was the potential to lose his practising certificate and felt the majority of doctors were being punished for the sins of the few. He tried to research more about RPR but did not know any colleagues who had been reviewed and felt the information on the website was not adequate. Dr D also felt having to tell his patients he was being *"checked up on"* was *"destructive of public trust"* because it implied there was something to check up on. Before the visit he expected *"a bit of a grilling"* and to hear he was good for another three years and didn't expect much more.

Dr D had no problems with the preparation for the visit, it was a mild annoyance and he thought he probably over prepared. Once he was in direct contact with the reviewer he thought it was straightforward.

Once the visit was complete Dr D's opinion of RPR changed dramatically. 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 D works. Dr D talked about matching reviewers with doctors being of *"utmost importance"*.

During the visit and in the RPR report the reviewer suggested changes Dr D 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 D 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 D felt the review was *"very fair, accurate and a really worthwhile exercise".*

Considerations from Dr D's feedback

Dr D's initial impression of RPR arose from his slight misunderstanding of the process. He suggested giving people who had not been reviewed an example report to show the areas addressed in a review.

There were two important aspects of the visit which helped to change Dr D's attitude. Matching him to an appropriate reviewer in both seniority and area of medicine, and providing helpful and actionable suggestions to multiple areas of practice, including administration, clinical practice and continuing education.

6.4.3. The reviewer

Systematic reviews by Miller 2010 and Veloski 2006 found changes to practice were more likely to occur when feedback was from a credible source and feedback was likely to be more effective when it was from a supervisor or senior colleague. Reviewed doctors highlighted the value of an objective view on their practice from someone they respected. The majority of responding doctors (81%) reported their reviewer demonstrated appropriate skills to evaluate their practice. Only a small percentage disagreed (Figure 13).

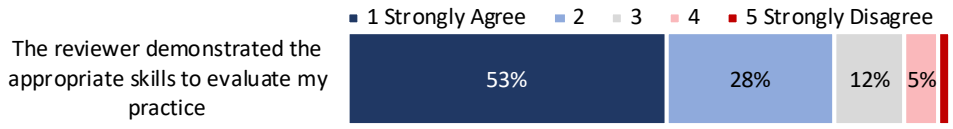


Figure 13. Doctors' views on reviewer skills (Post-RPR survey, n = 295)

Doctors' opinions of their reviewer were closely related to their likelihood of making changes to their practice and their overall opinion of RPR. Figure 14 and Figure 15 show reviewed doctors who had positive opinions of their reviewer were more likely to make changes and more likely to recommend RPR positively to their colleagues.

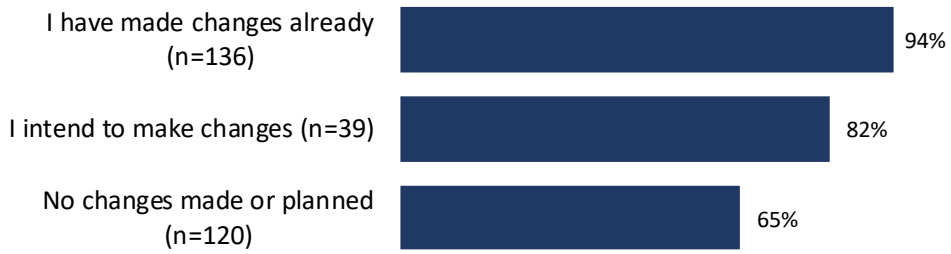


Figure 14. Percentage of doctors who agree their reviewer demonstrated the appropriate skills to evaluate their practice by those who have, intend to or have not made changes (Post-RPR survey)

Figure 15. Percentage of doctors who agree their reviewer demonstrated the appropriate skills to evaluate their practice by those who would or would not positively recommend RPR to their colleagues (Post-RPR survey)

There is a slight trend towards doctors not working in general practice becoming more positive about their reviewers over time, but this trend has not reached significance (Figure 16). This may reflect bpac^{nz} work to match doctors with reviewers who work in their speciality and have an appropriate level of seniority, though a small number of doctors were still not happy with their reviewer match.

I would like to see the match of reviewer to reviewee be better.

There is a decrease in the percent of doctors working in general practice who agreed their reviewer had the appropriate skills to review them.

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.

So matching the seniority and making sure the reviewer is familiar with the branch of medicine is very important. And with my visit I was very impressed. So whatever effort it takes to continue that, it's worth it.

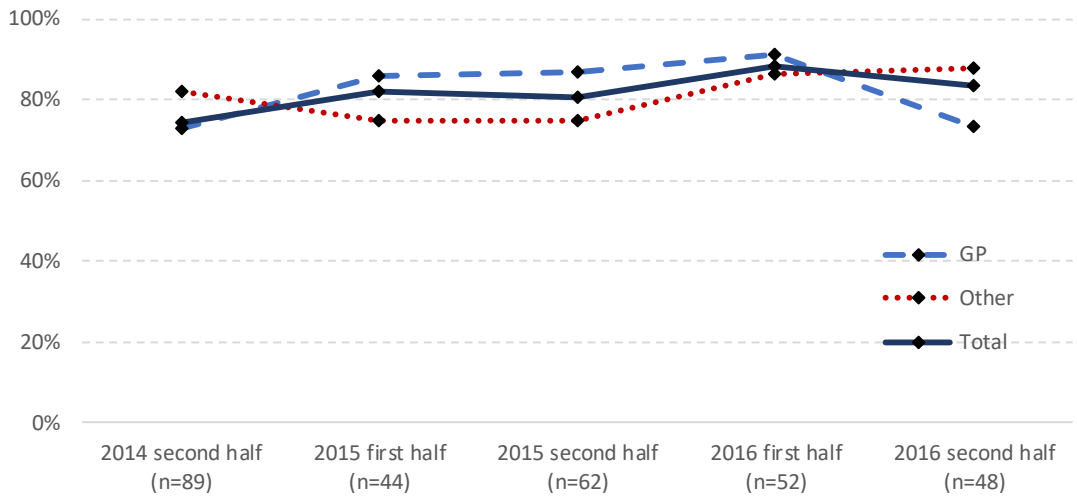


Figure 16. Percentage of doctors' agreeing their reviewer had the appropriate skills over time by current role (Post-RPR survey, total n = 295, Working in general practice n = 174, Not working in general practice n = 121)

Doctors who misunderstood the purpose of the review (seeing it as a pass/fail practice audit) seemed to place a higher importance on the expertise of the reviewer in their area of practice.

A small number of doctors made negative comments about their reviewer's conduct both in the reviewer's content knowledge and interactions. An example of this is outlined in the below case story.

Dr E's second RPR was not a collegial experience

Dr E has now had two RPR's. She enjoyed her first RPR and gained a lot from the experience but felt her second was a disappointment. In her first RPR the reviewer had some interest in Dr E'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.*

The reviewer from her first RPR created a collegial environment with a reciprocal exchange of ideas and knowledge which facilitated a positive, peer review like discussions about patients and discussions on Dr E's current CME. In contrast Dr E found the latest RPR was not collegial and felt like it was more of an exam/test situation.

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

Although the reviewer did suggest a few potential minor improvements which Dr E agreed with, she did not feel it was worthwhile and did not enjoy the

experience. This was a disappointment to Dr E as she had enjoyed her first experience of the RPR and was hoping to have another productive collegial day.

> *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.*

Considerations from Dr E's feedback

In this situation, there was a need for the reviewer to have some understanding of the area the reviewed doctor worked in.

Creating a collegial experience between the reviewer and reviewee is important when trying to create a positive experience and gain the most from the RPR. In this example, most changes Dr E implemented were viewed as tick box exercises and he did not agree with the need for them.

6.4.4. Variation in response to reviewers

Linking post-RPR and 12 month survey responses from doctors to their reviewers highlights some differences between reviewers. Reviewers at the top of Table 17 had the highest proportion of doctors reporting changes in practice, along with other positive outcomes. Those in the lower section had the lowest proportion of positive responses in most areas.

Table 17. Cells show the percentage of doctors with positive results in each area for each reviewers. Only reviewers who reviewed at least five survey respondents are included in the table. (Number of reviews done by reviewer n = 5-20, Doctor n = 247, Reviewer n = 21) (bpac^{nz} data matched to post-RPR survey)

Reviewer	Active in last 8 months	Have made changes to practice	Have made changes to PDP	Learnt new development opportunities	Visit was a positive experience	Would recommend RPR	Positive about reviewer
1	N	78%	78%	67%	89%	89%	89%
2	N	67%	50%	83%	100%	83%	100%
3	N	69%	81%	69%	81%	88%	88%
4	N	82%	82%	64%	82%	82%	82%
5	Y	67%	78%	67%	89%	72%	89%
6	Y	67%	100%	67%	67%	50%	83%
7	Y	45%	64%	64%	100%	45%	82%
8	N	50%	67%	58%	67%	58%	83%
9	Y	50%	33%	67%	83%	50%	100%
10	Y	40%	30%	55%	85%	65%	90%
11	Y	38%	38%	63%	63%	50%	100%
12	N	58%	42%	33%	75%	67%	67%
13	Y	53%	59%	59%	53%	41%	76%
14	Y	33%	58%	50%	67%	58%	67%
15	Y	29%	29%	53%	76%	53%	88%
16	Y	80%	60%	40%	40%	40%	60%
17	Y	40%	40%	40%	60%	60%	80%
18	Y	42%	25%	50%	58%	75%	58%
19	Y	27%	45%	27%	64%	55%	82%
20	Y	35%	30%	40%	45%	35%	65%
21	Y	15%	31%	46%	54%	23%	54%
Average		**52%**	**54%**	**56%**	**72%**	**61%**	**81%**

Differences between reviewers may result from non-random allocation of doctors to reviewers. Some reviewers may consistently be allocated more challenging doctors. The number of reviews completed by a reviewer did not appear to be a factor. The differences between reviewers may also reflect variation in reviewer capability. For example, low rates of practice and PDP change paired with a high rate of recommendation could indicate the reviewer was not able to identify any development opportunities, either because there were none or because the review was not robust enough.

Reviewers have strengths and areas for development. For example, a smaller percentage of doctors reviewed by reviewer 10 made changes to their PDP compared to other reviewers. This may indicate reviewer 10 could put more emphasis on encouraging PDP changes. Higher percentages of doctors reviewed by reviewer 15 had a positive experience and were positive about the skills of the reviewer.

Comparison between reviewers also highlights the correlation between making practice and PDP changes and whether the reviewer identified new opportunities for development. Reviewers tended to have high success rates in all or none of these areas. However, some doctors had high opinions of their reviewer even where they did not make practice changes.

6.5 Feedback received

The content and delivery of feedback has been shown to influence whether changes to practice are made (Pelgrim 2013 and Ivers 2012). The Ivers 2012 review found feedback may be more effective when it is provided both verbally and written, and when it includes measurable targets and a plan to achieve them. This is pursued in the form of SMART goals (specific, measurable, achievable, realistic/relevant, trackable).

Miller 2010 and Pelgrim 2013 discuss how feedback and suggestions for change should ideally be linked to the doctor's previously identified strengths and weaknesses as it makes any suggestions more relevant. 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 (Archer, 2010).

In RPR, feedback is provided verbally through discussion between the reviewer and the participating doctor during the practice visit. The feedback is formalised in a written report delivered after the review. Reviewers discuss strengths and opportunities for development with doctors and link them to PDP goals. Reviewers aim to ensure all points for development are discussed with the doctor during the practice visit so that the report does not contain any surprises.

As more doctors complete their second RPR there is an opportunity for reviewers to concentrate on the suggestions for change from the previous RPR and follow up on 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.*

6.5.1. Relevance of feedback

Pelgrim 2013 reports that reflection occurs when specific feedback is provided and doctors who reflect on their performance are more likely to make use of feedback. In interviews, doctors often identified the opportunity for self-reflection as one of the benefits of RPR.

The perceived relevance of the feedback from the reviewer is an important factor in whether doctors act on suggestions. If the doctor can see the reason for the suggestion then it is much more likely to be taken seriously. For example, a reviewer suggested to one doctor they should lower their chair. The doctor thought the suggestion was a waste of time and the reviewer was just trying to find something to comment on. Without explanation the suggestion could seem insignificant, but could be taken more seriously if framed in a way that explains a lower chair can make patients feel more comfortable.

6.5.2. Feedback content

RPR reports are the formal mechanism for providing feedback. In the RPR evaluation, two-thirds (67%) of doctors found the RPR report useful and more than half (55%) that it identified new opportunities for development (Figure 17). 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.*

Doctors responded very negatively if they felt the reviewers feedback and recommendations were clinically incorrect. This was only raised by a very small number of doctors.

> *They just criticised everything and it was all medically incorrect. It was just hard to be criticised the whole time with this medically incorrect information.*

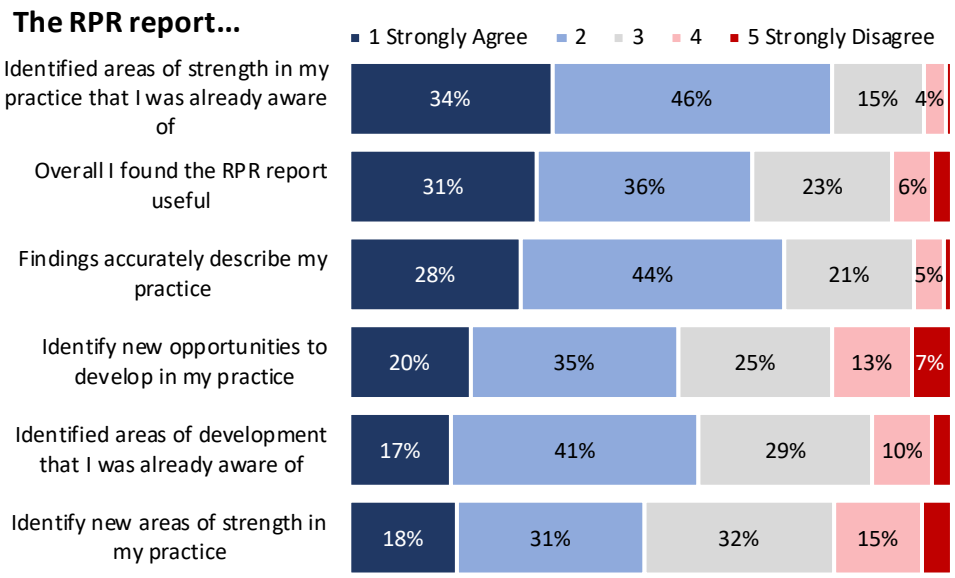


Figure 17. Doctors' views on the RPR report (Post-RPR survey, n = 295)

Feedback should be incorporated into the learning process by relating it to learning goals and plans for improvement (Archer, 2010). The doctors who learned new opportunities for development in their report were significantly more likely than those who did not to make changes in their PDP, practice and be more positive about RPR (Table 18). This highlights the importance of reviewers identifying new opportunities for development for participating doctors.

Table 18. Impact of learning new opportunities for development on making changes to practice, PDPs and how positively doctors rated RPR (Post-RPR survey, n = 295) (Statistically significantly differences are in bold)

	Number of doctors	Have made changes to their PDP	Have made changes to their practice	Would recommend RPR to their colleagues
Learned no new development opportunities	134	**47 (35%)**	**30 (22%)**	**46 (34%)**
Learned new opportunities for development	161	**99 (61%)**	**106 (66%)**	**123 (76%)**

Making practice change requires doctors to understand the steps required to respond to development opportunities. Almost all (86%) doctors who had new opportunities for development identified agreed the action needed to address the new development opportunities was clear.

In the group of doctors who reported not learning any new opportunities for development, there were more significantly more doctors who had superior ratings in clinical practice, compared to the group which did have new learning opportunities (Table 19).

Table 19. Percentage of doctors who received all superior ratings (seven or above) in each category of RPR compared to if they reported learning new opportunities for development (bpac^{nz} and Post-RPR survey data)

	Proportion with an average superior rating (7-9) for each category			
	Records/ requirements	**Dr patient relationship**	**Clinical reasoning**	**Clinical practice**
New opportunities learned (n = 146-150)	51%	59%	49%	**45%**
No opportunities learned (n = 125-128)	46%	63%	59%	**57%**

The perceived accuracy of the RPR report also appears to be associated with whether changes were made and the overall impression of RPR. One-quarter (27%) of doctors who were neutral or disagreed their report was accurate reported making changes compared to 54% of those who agreed their RPR report was useful. The majority of the group who did not think their report was accurate (69%) would also not positively recommend RPR to their colleagues (Table 20).

> *The report was very accurate, he definitely understood what I do differently to other doctors and the same as other doctors…. If he hadn't written it, I would have forgotten all the detail after a few months so the report is pretty essential.*

Table 20. Accuracy of report compared to changes made and overall impression of RPR (Post-RPR survey, n = 295) (Significant differences are in bold)

	Number of doctors	**Have made changes to their PDP**	**Have made changes to their practice**	**Would recommend RPR to their colleagues**
Agree the report was accurate	213	109 (51%)	**114 (54%)**	**146 (69%)**
Neutral or disagree the report was accurate	82	37 (45%)	**22 (27%)**	**23 (28%)**

Analysis comparing RPR results with how accurate doctors felt their reports were, showed that more doctors who received all superior ratings in all categories agreed their report was accurate (Table 21).

Table 21. Percentage of doctors who received all superior ratings (seven or above) in each category in RPR compared to if doctors thought their report was accurate (all differences were significant) (bpac^{nz} and Post-RPR survey data).

	Proportion with an average superior rating (7-9) for each category			
	Records/ requirements	Dr patient relationship	Clinical reasoning	Clinical practice
Agreed their report was accurate (n = 195-198)	**56%**	**68%**	**62%**	**55%**
Did not agree their report was accurate (n = 76-80)	**31%**	**42%**	**33%**	**37%**

6.5.3. Patient and multi-source feedback

Doctors participating in RPR provide patient and/or multi-source feedback in advance of their RPR practice visit. Miller 2010 has shown multi-source feedback can lead to practice improvement, although the context and help in facilitation to make changes also has a large effect on the usefulness of multisource feedback. In the RPR evaluation, 44% of doctors agreed the multi-source feedback provided useful information and 33% agreed the patient feedback provided useful information. Patient feedback was reported as not applicable for one-third of doctors (Figure 18).

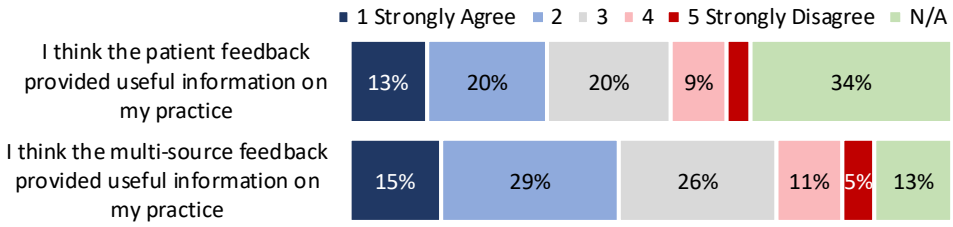


Figure 18. Doctors' views on colleague and patient feedback (Post-RPR survey, n = 295).

A short summary of how one doctor received useful feedback and made changes is provided below.

Dr F – Very positive about RPR

Having graduated around five years ago, Dr F considers himself a junior doctor. He has worked in urgent care medicine but now works in general practice where he was reviewed.

Dr F felt he was working mostly on his own and it was easy to be isolated from his peers, especially working in urgent care where often only one doctor worked at a time. The majority of his interactions with other doctors were about patients he was referring.

Dr F was pleased to have the opportunity to take part in RPR.

> *I found it very helpful to actually get the opportunity to have another doctor sit in on my consults and to be able to comment on what I could improve and what I was doing well…. These sorts of opportunities don't come around very easily in primary care.*
>
> *It was an opportunity to work in a less isolated way…. It's easy to get stuck in the mind set of doing it one way, and it was really good getting another doctor's opinion... There are many ways to skin a cat so it's good to see what other people are doing out in primary care.*

Dr F found the visit so helpful he suggested it could be good to have the visits more often, potentially up to one a year.

RPR did more than just reduce isolation for Dr F. He also reported making significant changes to his practice because of the 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.

> *So basically, coming from a background where……. 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.*

Dr F also discussed how RPR helped him understand and implement his PDP more effectively as well as being more engaged with his own self-monitoring such as note reviews and audits.

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 F went on to create two e-portfolio goals directly after RPR to address the RPR feedback.

Considerations from Dr F's feedback

Dr F understood the purpose and the intention of the RPR which resulted in him having a positive attitude towards the whole experience.

Dr F also received multiple tangible suggestions for how to improve his practice which allowed him to make positive changes.

6.5.4. Follow-up

The extent of follow-up after the written RPR report depends on the individual doctor. If there were any concerns or non-compliance issues raised by the RPR, bpac^{nz} follows up with the doctor. Doctors who have no areas of concern do not generally receive further feedback or follow-up until their next RPR (three years later).

After RPR, doctors are encouraged to speak with their collegial relationship provider (CRP) about their RPR report and plan for how best to utilise the feedback. Doctors most often discussed their PDPs with their CRP, followed by other colleagues, the RPR reviewer and/or a supervisor (Table 22). During the preliminary conversation with the CRP it may be helpful to make a point of suggesting the CRP follow up about the RPR report and have it as part of their agenda for their next meeting.

Table 22. Who doctors discussed their PDP with (Post-RPR and 12 month survey).

Person PDP discussed with	Post-RPR (n = 295)	12 months later (n = 133)
Collegial relationship provider	67%	62%
Other colleagues	41%	44%
RPR reviewer	40%	9%
Employer/manager	22%	22%
Other	14%	-
Inpractice medical advisor	-	9%

There is an opportunity for the CRP and/or the reviewer to be more involved in the feedback and create an action plan following the RPR. This could help to reaffirm/consolidate the feedback and provide encouragement from multiple

sources. It is important to consider the extra time commitment if more RPR follow-up is expected whether from CRPs or reviewers.

CRPs give the doctors feedback on a more regular basis than RPR occurs. As noted above, the reviewed doctors most commonly discussed their professional development plans with their CRPs. Comments from RPR doctors and their CRPs highlighted variation in the quality of the collegial relationships.

As expected under the *Inpractice* collegial relationship requirements, the relationships involved a combination of informal discussion of particular cases (by phone, email or in-person) and formal and regular meetings. Where relationships were strong, they appeared to be of substantial value in supporting the doctors' professional development and the CRPs felt that they were contributing to improvements in the doctors' practice.

In other cases, the CRP 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 skills or experience to do so.

Table 23 provides comments from CRPs on their collegial relationships with RPR doctors.

Table 23. Feedback from CRPs on their collegial relationships with RPR doctors.

Examples of CRP relationships in practice	
Discussing RPR	***Do discuss RPR:*** *[Have you discussed his RPR?] Yes, we have. There was definitely no surprises and I didn't have any concerns, if I had any concerns they would have been highlighted a long time ago.* ***Do not discuss RPR:*** *We haven't spoken about his RPR.*
Nature of CRP relationship	***Working closely helps CRP role:*** *I think ours is absolutely effective and the strength of it is we are consulting and working in the same facility and I'm always available and there is not a day goes by that we don't talk about something, so it's hard to imagine that it's not effective.* ***Being external is good:*** *I think I give him a chance to talk through certain cases and we can have a frank discussion about things because I'm not working directly with him or anything.*
Knowledge of what CRP role is	***Completes the CRP role:*** *We talk about what she has done since the last meeting. Her reflection on her activity, what she plans to do next, her priorities, areas she can focus on so we concentrate on progressive things*

	rather than maintaining the status quo. She brought along her RPR report with her and we went through it. ***Not sure of CRP role:*** *I'm not sure if I'm fulfilling my role as a CRP adequately, like we are all very busy doctors and we get asked to do the CRP thing and we say yes and we are happy to do it but I haven't gone and read up on what I am meant to be doing… I would have like some guidance around what I'm supposed to be doing.*
How regular CRP sees doctor	***See them often:*** *I see James every day as we work in the same facility, we are consulting within a few meters of each other and when he's operating I'm generally around… We still have the more formalised meetings every month or so but the reality they are every day we are talking about this or that.* ***Do not see them often:*** *I think [I have seen the doctor] three times in the last 12 months.*
Impact of CRP on doctor	***Big Impact:*** *I'm sure his practice has been moulded by our specialist practice here and as we are trying to deliver the absolute pinnacle of care for what we do here, and we've worked alongside each other for a long time.* ***No impact:*** *I don't know that I've changed anything, it's been more support and as for how useful it's been that probably a moot point to be honest. I guess she's grown up in a different kind of culture that there is now, and this mentoring and so on is probably not as well accepted by the older doctors and it's something that has been forced on us rather than something people have opted for.*

7. The RPR reviewer perspective

The reviewers have a key role in the RPR process. Survey results indicate reviewers are positive about all aspects of RPR, consistent with previous reviewer surveys.

- Almost all reviewers felt they had the necessary training, support and information about the doctor to be effective reviewers.
- More than half wanted to do more reviews while just under half were happy with the number of reviews completed. About one review per month was the ideal number of reviews for most reviewers.

Reviewers were confident their feedback could enable changes in practice that would improve care for patients. However, they were uncertain if changes took place because they did not have any follow-up contact with the doctors they reviewed.

Giving feedback is a skilled role. Developing the reviewers' ability to provide feedback on opportunities to develop the reviewed doctors' practice has been a focus of reviewer training. Further development for reviewers has the potential to strengthen RPR. Aspects of reviewer development suggested by the evaluation are:

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

Reviewers raised a range of potential areas for improvement for them as reviewers. These include personal feedback from the reviewed doctors on how they found the review, feedback from bpac^{nz} on what follow-up has happened when concerns were raised to learn about what is taken seriously and what the outcomes are. Time demands can be quite high for some reviews and the remuneration may need to increase to cover this.

Some reviewers suggested further follow-up with reviewed doctors over the phone could be good whilst others were not interested in this.

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

7.1 The reviewer surveys

The evaluation has sought feedback from reviewers through surveys of all reviewers and interviews with samples of reviewers. This report includes the findings of the third reviewer survey completed in February 2017. Invitations were sent to all 19 active reviewers and 17 responded.

Almost all (88%) of the reviewers surveyed were still in clinical practice. The two reviewers not in clinical practice had been out of practice for one year. Most of the reviewers had between 20 and 40 years of practice experience.

All results reported in this report are from the February 2017 survey of reviewers. Quotes are from the 2016 and 2017 interviews.

7.2 Reviewer training and preparation

RPR reviewers reported they had the necessary support and training to carry out effective reviews and had sufficient information about the doctor being reviewed. Most strongly agreed or agreed and none disagreed with any of the three statements in Figure 19.

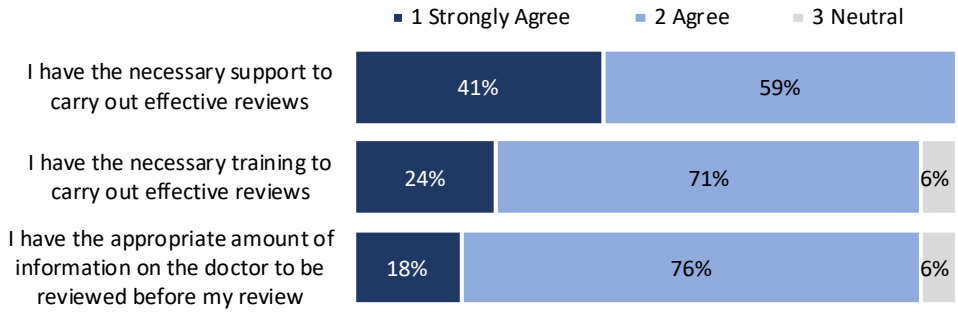


Figure 19. Reviewers' views on their preparation for the reviewer role (Reviewer survey, n = 17).

All interviewed reviewers thought they received very good support for their role. Reviewers were happy they were able to call bpac^{nz} and ask questions. They thought communication from bpac^{nz} was prompt and simple to follow.

Reviewers reported the training sessions and material for the role were well organised and useful, and catching up with other reviewers was a valuable experience.

> *I think so it was very clearly laid out for what was expected of the reviewer. And had a good training day which pointed out most of the issues we are likely to encounter. I think Inpractice and bpac^{nz} are supportive of any problems that might come up.*

7.3 Reviewer workload

Under half (41%) of the reviewers thought they were completing about the right number of reviews, while the remaining 59% ideally wanted to complete more reviews in the next 12 months than in the past 12 months (Figure 20). The average number of reviews completed by those who wanted the same number of reviews was eight and those that wanted more had completed an average of five reviews in the last 12 months.

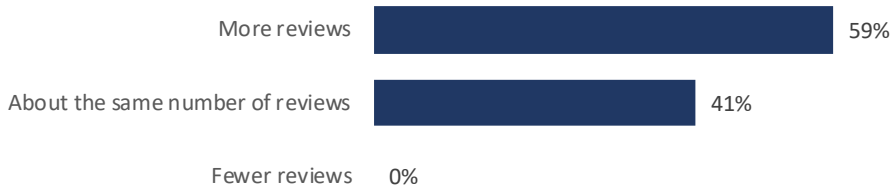


Figure 20. Reviewers' views on the number of reviews they would like to complete in the next 12 months (Reviewer survey, n = 17).

The ideal number of reviews seemed to be between eight and 12 each year, but this depended on the individual reviewer. A number of reviewers explained this number of reviews gave them the opportunity to stay current and to benchmark the reviews they completed against each other.

7.4 Reviewers' perspectives on doctors' reactions to RPR

RPR reviewers reported they were positively received by doctors. Most agreed doctors were receptive to the practice visit and the reviewers' feedback, although 6% disagreed that doctors seemed receptive to the visits (Figure 21).

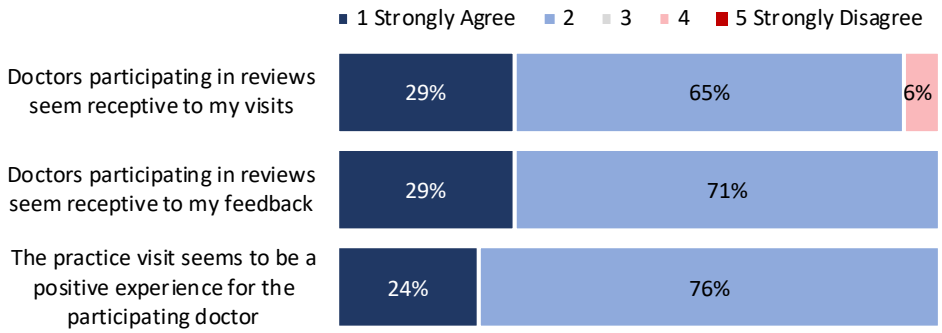


Figure 21. Reviewers' views on doctors' reactions to RPR (Reviewer survey, n = 17).

7.5 The practice visit and feedback to doctors

Almost all reviewers were positive about the practice visit and the feedback they were able to provide doctors (Figure 22). Only 6% of reviewers were neutral about being able to provide adequate feedback through the RPR feedback tools.

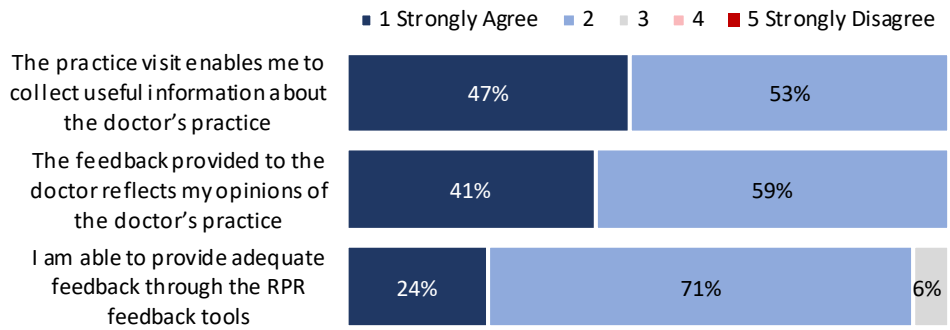


Figure 22. Reviewers' views on the practice visit and feedback to the reviewed doctors (Reviewer survey, n = 17).

Most reviewers described the opportunity the practice visits provided for face-to-face discussions with the doctors as essential, and in some cases the most valuable part of the review.

> *[The practice visit] it's quite valuable because you can really watch what's happening, so yes it's really worthwhile.*

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, often explaining RPR was not an audit of their fitness to practice.

> *I try to let them know that I'm a peer, not one step above them and I always give them a call beforehand to introduce myself and put them at ease just to make the whole thing more normal. I just try to reiterate I'm there to help really.*

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.

> *[The debrief session] is a little challenging but it's very useful to cover the things that you've already spoken about. I try and make it so I don't bring something out of the blue, so I try to talk about things as they come up. Also try to leave them feeling positive about the whole thing.*

The report template has changed over the last three years. All of 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.

[The report is] great to look back on it too, you can't remember it all on the day.

7.6 Views on RPR's effectiveness

Most reviewers thought RPR would enable doctors to make changes to their practice and thought RPR contributed to improving the care delivered to patients (Figure 23).

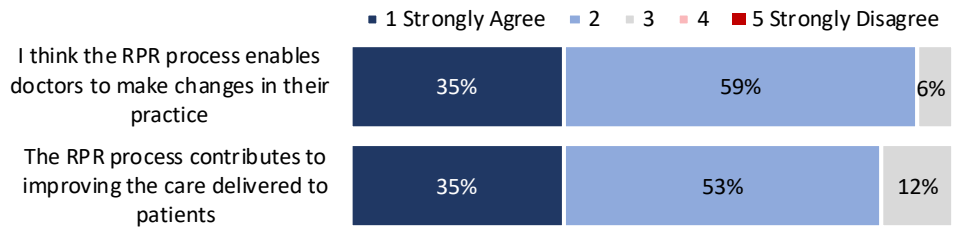


Figure 23. Reviewers' views on whether RPR contributed to changes in practice and improvements in care delivered to patients (Reviewer survey, n = 17).

Although reviewers thought doctors were receptive to feedback, not all were sure doctors would make changes to their practice. Their uncertainty most often related to not having any direct feedback from doctors or follow-up with the doctors after RPR to discuss whether changes were made.

It's hard to know [if my recommendations have been acted upon] because I haven't gone back and looked at the e-portfolio or spoken to them so I can't gauge that. But I think my comments were taken seriously and probably will be acted upon.

All reviewers said they discussed PDPs with the doctors they reviewed. While they were generally confident the feedback they gave would result in changes, they did not have the opportunity to see the changes.

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

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

Although doctors with higher ratings are less likely to makes changes, the primary purpose of RPR is to help maintain and improve the standards of the profession[10]. Even if doctors are not making changes the RPR could help them maintain their skills.

7.7 Benefits for reviewers

Reviewers were positive about their roles with nearly all reviewers surveyed agreeing the role had been a positive experience and had improved their own practice (Figure 24).

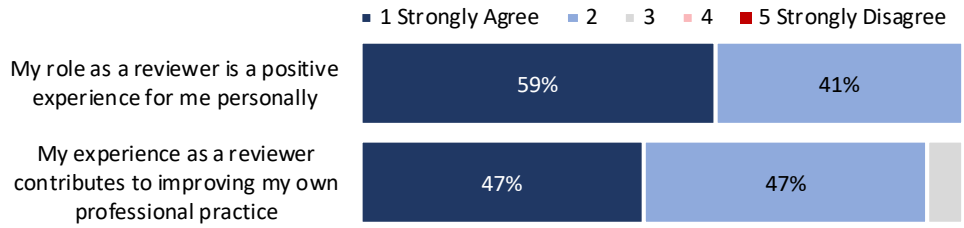


Figure 24: Reviewers' views on how positive the role is and if it contributes to their own practice (Reviewer survey, n = 17).

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

> *I think I'm the one who probably learns the most. It is very interesting and informative visiting different practices and seeing how different practitioners and services are organised.*

Reviewing doctors in other areas of practice was a good way for reviewers to expand their knowledge. However, many reviewers were not comfortable reviewing doctors in different areas of practice. The majority of reviewers spoken to did not feel confident reviewing doctors in different area of medicine to their own, but were comfortable reviewing doctors in similar fields.

> *I don't think I could review a GP or a surgeon (nor would I be willing to).*

> *I wouldn't have a clue if I spoke to someone doing something like appearance medicine, so I think it's really important to have the right reviewer for the person being reviewed.*

Reviewers were also positive about the respect and value others in their profession placed on their role (Figure 25).

[10] Council's policy on regular practice review: https://www.mcnz.org.nz/assets/Policies/Policy-on-regular-practice-review.pdf

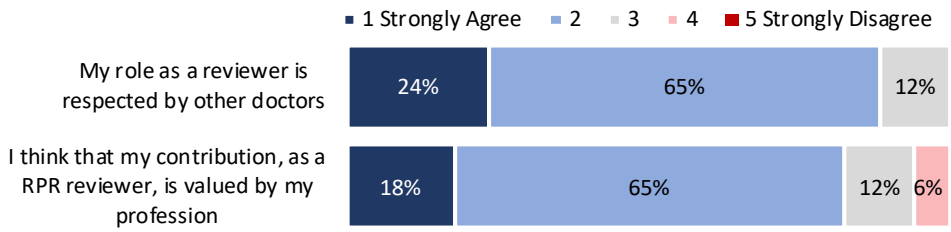


Figure 25. Reviewers' views on the perception of them among other doctors (Reviewer survey, n = 17).

7.8 RPR reviewer suggestions for improvement

Reviewers suggested potential ways to improve the reviewer role and to strengthen the RPR programme:

- Ensure a training session is attended before starting as a reviewer
- Regular reviewer meetings: Ensure reviewer meetings are held annually.
- More feedback for reviewers on RPR: Some reviewers suggested more personal feedback from the reviewed doctors about how they could improve their skills as reviewers and what helped the RPR process be successful for the doctors being reviewed.
- More feedback for reviewers on reporting concerns: It was suggested that bpac^{nz} could provide feedback to reviewers about any concerns they raised so they would know if their concern was valid and what is expected in this area.
- Time demands: Completing travel to and from the reviewed doctor and conducting the practice visit in a single day was demanding for some of the reviewers. They suggested when there was a significant amount of travel required, extra time and overnight accommodation could be appropriate.
- Increased fee: Some reviewers felt that the time needed to complete some reviews was too much for the pay they received.

Suggestions for improving RPR in general included:

- Reviewers could potentially follow up with participating doctors at a later date to continue to encourage change. Although this does entail more time commitment from the reviewers.
- Strengthening PDP expectations and explaining what this entails: Many reviewers said some reviewed doctors did not understand the process of developing an effective PDP or see the point in it.
- Collegial Relationship Providers (CRPs): Giving the CRPs a more formal role in RPR could strengthen the relationship between the CRP and the reviewed doctor and encourage further reflection on the RPR. CRPs could benefit from

a more thorough explanation of what is expected of them in their capacity as CRPs.

Reviewers have contact with the CRP prior to the practice visit as well as having a pre-visit discussion with the doctors to outline the process. Most doctors and reviewers advocated for phone contact to begin building rapport and address any concerns.

The skills of the reviewers continue to be developed by bpac^{nz} through investment in training sessions.

8. Overview

8.1 Evidence base

The RPR design is based on evidence wherever possible. A review of the literature has provided evidence that audit and feedback can improve practice and which can potentially improve the quality of care patients receive:

- CME does improve physician performance and patient health outcomes, and CME has a more reliably positive impact on physician performance than on patient health outcomes (Cervero and Gains, 2015).
- Interactive CME such as outreach visits, and audit and feedback generally lead to small but potentially important improvements (Bloom 2005 and Davis et al., 1995), but effectiveness is linked to baseline performance and how feedback is delivered. A senior colleague, respected by the doctor, is ideally placed to provide effective feedback (Ivers et al., 2012, Veloski et al., 2006 and Miller and Archer, 2010).
- Appraisal can have a significant impact on all aspects of a GP's professional life, and those who value the process report continuing benefit in how they manage their education and professional development (Colthart et al.,2008).
- Multi-source feedback can lead to performance improvement but the context and facilitation of the feedback influenced the degree of improvement (Miller and Archer, 2010).
- Outreach visits have small but consistent effects on prescribing but the effect of outreach visits on other types of professional performance varies between studies from small to modest improvements (O'Brien et al., 2008).
- Reflection only occurs when a trainer has provided specific feedback; trainees who reflect on their performance are more likely to make use of feedback (Pelgrim et al., 2013).
- Feedback as part of workplace based assessment is of greater benefit to trainees if: (i) observation and feedback are planned by the trainee and trainer; (ii) the content and delivery of the feedback are adequate, and (iii) the trainee uses the feedback to guide his or her learning by linking it to learning goals. Negative emotions reported by almost all trainees in relation to observation and feedback led to different responses (Pelgrim et al., 2012).
- CPD is valued and is seen as effective when it addresses the needs of individual clinicians, the populations they serve and the organisations within which they work (Schostak et al., 2010).

8.2 Doctors are rating highly in the RPR categories

Doctors review ratings, colleague feedback and patient feedback were analysed. It was found that:

- Over half of doctors had superior ratings
- Nearly all doctors were rated between four or five out of five in all categories by their colleagues (one is negative, five is positive)
- Nearly all doctors were rated between four or five out of five in all categories by their patients (one is negative, five is positive).

8.3 Doctors are reporting making changes to their practice and professional development plans

Many of the participating doctors have made changes to their practice and their PDPs. While these are self-reported changes, they provide evidence that RPR is achieving its aims for many of the participating doctors. Twelve months after their review, just under half of the participating doctors continued to report changes in practice. The changes they described are likely to improve the quality of care they provide to their patients.

At 12 months, learning about new opportunities for development from the RPR process appears to be closely linked to the likelihood of making changes. However, other factors may become significant as the numbers completing the 12 month survey increase.

8.4 Maintaining changes over time

Twelve months after RPR, a substantial proportion of doctors reported changes in practice. Time series analysis of key outcomes does not yet show improvement over time but the available data are still limited. This aspect of the evaluation will continue to be developed as more doctors complete RPR.

Current data show a slight decrease in the proportion of doctors who reported they had made changes between the post-RPR and 12 month surveys. Looking at the characteristics of the different groups it appears that the doctors who did not maintain changes were still positive about RPR and may have misreported changes at 12 months.

The majority of those who intended to make changes in the post-RPR survey reported they had not made any changes at 12 months. Those who intended to make changes were less positive about RPR compared to those who made changes but not as negative as those who did not. This suggests that changes are potentially more likely to happen if they are made close to the time of feedback.

8.5 Why changes are made

There are a range of reasons why doctors do or do not make changes to their practice and/or PDP.

A doctor's background and personal views can contribute to RPR outcomes in terms of changes made and overall experience. Those who are negative about the process are unlikely to make changes and utilise the opportunity of RPR, whereas those who are open to it and have a positive experience are more likely to make changes. The ease of organisation, how well the RPR process fits the individual doctor and how well the practice visit goes can influence doctors' experiences of the process and contribute towards their response to RPR as a whole. Doctors who were positive about their RPR were more likely to have made changes.

Statistically, post-RPR, doctors were more likely to have made changes if any of the following was true: were working in general practice, had English as a second language, learned new development opportunities and agreed their RPR report was accurate. Doctors who trained outside New Zealand were more likely to recommend RPR to their colleagues than New Zealand trained doctors.

Other aspects which made a difference to how positive doctors were included:

- Easy process/easy to organise
- Positive personal view of idea RPR
- Relevant to practice type
- No negative impact on patients
- Reviewer is collegial and credible
- Reviewer has similar background and skills
- Feedback is fair accurate and helpful, with tangible suggestions that doctors are not already aware of.

Ensuring that feedback is given in an effective manner and explaining how it can be incorporated into professional development plans could be a way to increase the impact of RPR.

With the small number of RPR participants in atypical practices it is not always feasible to match the reviewers' specialty area with RPR participants. It is important to ensure the reviewed doctors understand the purpose of the review, how it applies to their practice, how the practice visit process can be modified to take the particular characteristics of their practice into account and why the reviewer is qualified to undertake the review. It is important to note that as the scope of RPR has extended beyond doctors working in general practice, new reviewers in other areas of practice have been employed, including obstetrics and gynaecology, internal medicine, emergency medicine and psychiatry.

Misunderstanding the purpose of the review (seeing it as a pass/fail practice audit) appears to contribute to reviewed doctors placing a higher importance on the expertise of the reviewer in their area of practice. Some reviewers had this misunderstanding as well. This issue has been present throughout the evaluation but is expected to improve as knowledge of RPR and its purpose becomes more widespread and doctors are re-reviewed.

8.6 The reviewer perspective

Reviewers were generally positive about RPR. Some reviewers liked reviewing doctors outside of their speciality however the majority spoken to did not feel comfortable doing this. Reviewing a doctor in a different field posed challenges when they did not have enough knowledge to fully understand the reviewed doctor's role and clinical competence. Others did not view this as their role and instead thought that they could review professionalism and standards of practice without specific content knowledge.

8.7 Strengthening RPR

Surveys and interviews suggested some aspects of RPR where there is potential for improvement:

- **Clarity about the purpose of the review**. The experience for participants is generally positive and many of the doctors who have completed RPR would recommend it to their colleagues. However, some continue to consider RPR as an audit and this results in stress and anxiety.
- **Reassuring doctors about flexibility**. Some doctors, particularly in atypical practices, were concerned about how RPR would work for their practice. More reassurance in the lead-up to the review about how the schedule for the day might be modified to suit their practice could ease concerns and allow the doctor to be adequately prepared.
- **Providing adequate feedback to doctors who rate very highly**. Learning about new opportunities for development contributes to satisfaction with the review process. Approximately half of the reviewed doctors were rated very highly by their reviewers in all reviewed categories. While some welcomed confirmation they were providing a high standard of practice, others felt the process was not worthwhile. Attitudes may become more negative when the highly rated doctors are invited to complete a second review in three years.
- **Follow-up after the review**. Some reviewers were positive about having some 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. CRPs could be further encouraged to concentrate on addressing feedback from the RPR report and discussing what type of professional development could best address it.

8.8 Evaluation next steps

The evaluation will continue to collect data from RPR participants as they receive their reports and 12 months after they receive their reports. Additional completions will facilitate further time-series analysis. Some doctors will also complete their second reviews, which will allow comparison between results three years apart.

Analysis of bpac^{nz} data on professional development plans will be incorporated into the next report, which will be provided in late 2017.

9. References

Archer, J. C. (2009). State of the science in health professional education: Effective feedback. Medical Education, 44(1), 101-108.

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.

Boonyasai, R. T., Windish, D. M., Chakraborti, C., Feldman, L. S., Rubin, H. R., & Bass, E. B. (2007). Effectiveness of Teaching Quality Improvement to Clinicians. JAMA, 298(9), 1023.

Colthart, I., Cameron, N., Mckinstry, B., & Blaney, D. (2008). What do doctors really think about the relevance and impact of GP appraisal 3 years on? A survey of Scottish GPs. Br J Gen Pract British Journal of General Practice, 58(547), 82-87.

Davis, D. A, Thomson M.A, Oxman A.D, and Haynes R.B. (1995). Changing physician performance. A systematic review of the effect of continuing medical education strategies. JAMA: The Journal of the American Medical Association, 274(9), 700-705.

Hays, R. B., Davies, H. A., Beard, J. D., Caldon, L. J., Farmer, E. A., Finucane, P. M., . . . Sibbald, G. R. (2002). Selecting performance assessment methods for experienced physicians. Med Educ Medical Education, 36(10), 910-917.

Ivers, N., Jamtvedt, G., Flottorp, S., Young, J. M., Odgaard-Jensen, J., French, S. D., . . . Oxman, A. D. (2012). Audit and feedback: Effects on professional practice and healthcare outcomes. Cochrane Database of Systematic Reviews Reviews.

Miller, A., & Archer, J. (2010). Impact of workplace based assessment on doctors' education and performance: A systematic review. Bmj, 341(Sep24 1), C5064-C5064.

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

Pelgrim, E. A., Kramer, A. W., Mokkink, H. G., & Cees P M Van Der Vleuten. (2012). The process of feedback in workplace-based assessment: Organisation, delivery, continuity. Medical Education, 46(6), 604-612.

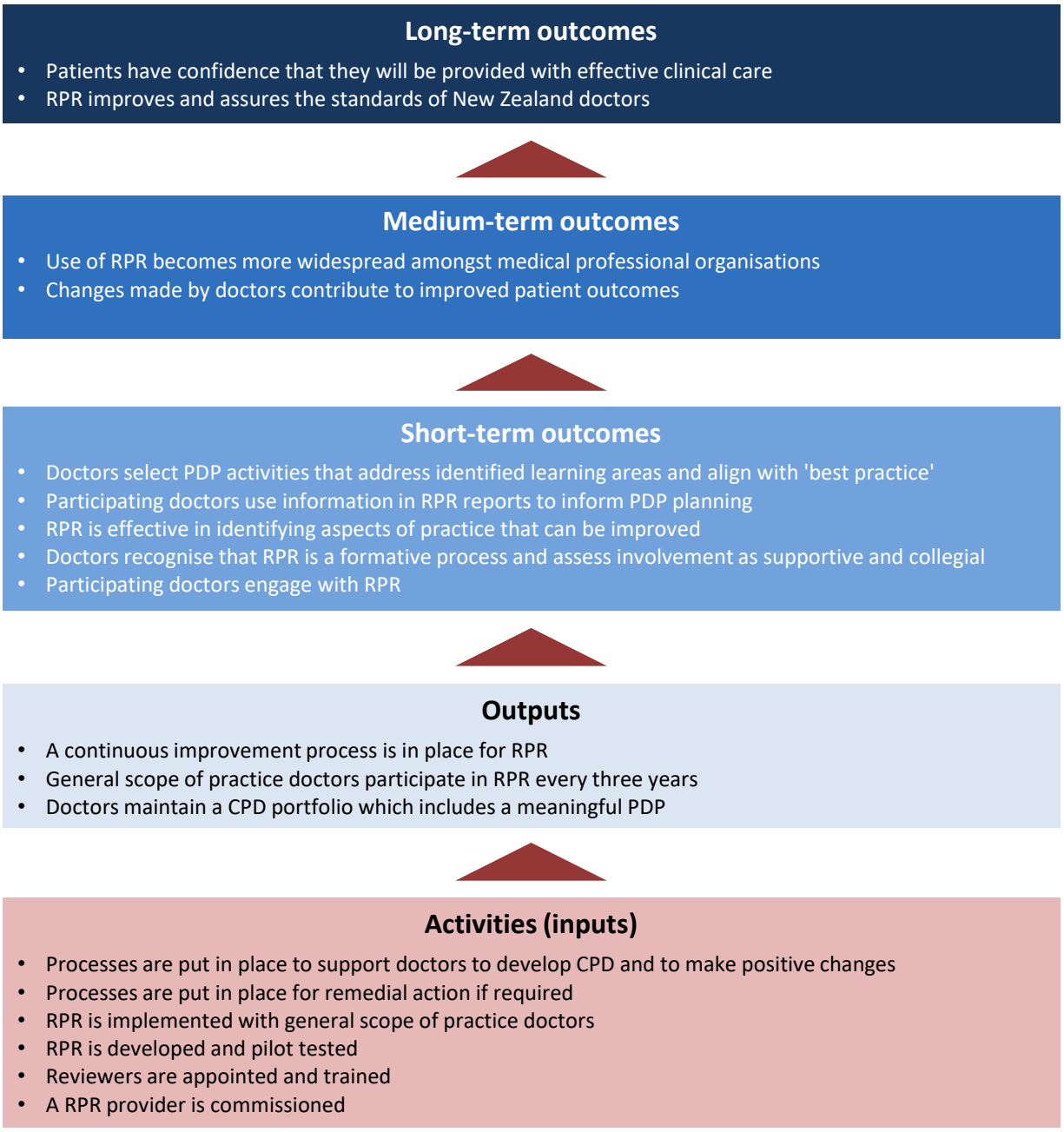
Pelgrim, E., Kramer, A., Mokkink, H., & Vleuten, C. V. (2013). Reflection as a component of formative assessment appears to be instrumental in promoting the use of feedback; an observational study.Medical Teacher, 35(9), 772-778.

Schostak J, Davis M, Hanson J, Schostak J, Brown T, Driscoll P, et al. (2010) Effectiveness of continuing professional development pro¬ject: a summary of findings. Med Teach;32(7):586–92.

Veloski, J., Boex, J. R., Grasberger, M. J., Evans, A., & Wolfson, D. B. (2006). Systematic review of the literature on assessment, feedback and physicians' clinical performance: BEME Guide No. 7. Medical Teacher, 28(2), 117-128.

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

Appendix One: Logic Model and Evaluation Framework



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

Evaluation Framework

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

	• Doctors provide examples of how they have developed a PDP in response to RPR feedback • Doctor's description of changes they intend to make as a result of the RPR process and report • Doctor's description of how they will put changes into practice	• Online survey of doctors
Do the doctors PDP address gaps identified in the RPR report?	• Doctor's PDP respond to gaps in their learning identified by the RPR report • Doctors plan PD activities that are consistent with 'best practice' approaches to learning e.g. comparison of activities that require participation versus those requiring more than participation e.g. quizzes, log of clinical encounters • Comparison of doctors planned and actual PD activities	• Expert advisors evidence about what works • bpac^{nz} records of PDP activities for RPR doctors • Interviews with collegial relationship providers
Reviewers' experiences of RPR		
What is included in the RPR process?	• Description of the reviewer's role • Description of how reviewers were recruited	• Interviews with bpac^{nz} • Interviews with reviewers
Do reviewers consider they are adequately prepared in their role as reviewers?	• 90% of reviewers rate preparedness for the role as prepared or very prepared • 90% of reviewers rate preparedness to use the RPR tools as prepared or very prepared	• Interviews with reviewers • Online survey of reviewers
Is the workload manageable for reviewers?	• 90% of reviewers report the workload is manageable	• Online survey of reviewers
Do the reviewers consider the RPR tools provide an accurate representation of the quality of the doctors they review?	• Reviewers report the RPR tools are effective – 90% of reviewers consider the tools provide an accurate or very accurate representation of doctors they review	• Review of RPR data for completeness • Interviews with reviewers • Online survey of reviewers

Are reviewers positive about the RPR process?	• Drop-out rates of reviewers is within expected limits • 80% of reviewers rate reviewing as a positive or very positive activity • Reviewers comments about changes to their own 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 • Doctor's description of how they worked with their collegial relationship providers	• Interviews with RPR doctors • Interviews with collegial relationship providers • Survey of RPR doctors
RPR achievements		
Do participating doctors assess the RPR process as useful in developing their 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	• 12 month online survey of doctors • 12 month interviews with doctors

What aspects of the tools are effective in predicting improvements in practice?	• Variables that are aligned to practice improvement	• Analysis of RPR tool data – factor analysis and multivariate analysis with outcome of practice improvement
Are there particular groups of doctors for whom RPR is more/less effective?	• Profiles of doctors with different outcomes	• Cluster analysis of data identifies clusters of doctors with different outcomes
Does the RPR programme represent value for money for the Council?	• Establish value for money criteria with the Council in the planning year • Monitor against value for money criteria	• Interviews with the Medical Council