Malatest International

Evaluation report: Mid-Year Progress Report

Evaluation of the Regular Practice Review Programme

October 2015

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1. Executive Summary

1.1 About RPR

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

For doctors, Council's aim is that all doctors (except those in vocational training) will have the opportunity to undertake a form of regular practice review that is a formative assessment. RPR has been implemented through the bpac^{nz} *inpractice* programme from July 2013.

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

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

1.2 About the evaluation

The Regular Practice Review (RPR) evaluation provides mid-year and end of year evaluation reports. This report updates the mid-year 2015 report to support a presentation by the Council Chair. Previous reports include:

- Interim 2014 report – November 2014
- End of year 2014 report – provided in March 2015
- Mid-year 2015 report.

As for previous reports, this report updates information drawn from interviews and surveys of doctors participating in RPR. Data have been collected at two points in time relative to doctors' participation (invitations sent approximately two weeks after receiving their RPR report and twelve months later).

- **Two weeks after RPR:** All doctors participating in RPR since June 2014 have been invited to be part of the evaluation through:

- Two-week online survey: Survey responses from 159 of the 236 (67%) RPR doctors who received their RPR reports between July 2014 and September 2015.
- Interviews: Doctors who complete the survey can opt-in to follow-up interviews to discuss in-depth their views on RPR. To date, 28 doctors have been interviewed.
- Interviewed doctors are also asked to provide the contact details of their collegial relationship providers so they can be contacted for an interview. To date, six collegial relationship providers have been interviewed.
- The participating doctors were primarily trained and working in general practice, though there was a smaller group who worked in other areas (for example, travel medicine or psychological medicine). They most often had between five and ten years of experience practising in New Zealand (30%), though 12% had more than thirty years of practice. More than one-third (36%) were trained in New Zealand and less than one-quarter (23%) in the UK.

- **Twelve months after RPR:** Doctors are invited to participate in the evaluation twelve months after their RPR visit through:
  - Twelve-month online survey: The twelve-month survey was completed by two groups of doctors: 32 of the 45 early cohort doctors who completed RPR between April and June 2014, giving a response rate of 71%; and 17 of the 31 (55%) later cohort doctors who also completed the two-week survey in June-September 2014.[1]
  - Interviews: Doctors who complete the twelve-month survey can opt-in to completing an interview. To date, four have been interviewed.
  - As with the two-week survey most of the participating doctors were primarily trained and working in general practice. They most often had between five and ten years of experience practising in New Zealand (37%), though 12% had more than thirty years of practice. More than one-third were trained in New Zealand (35%) and in the UK (37%).

1.3 Summary of findings

1.3.1. Changes to practice and professional development post-RPR

Nearly half (46%) of doctors had already made changes to their practice as a result of RPR and a further 13% intended to make changes.

[1] The response rate is expected to increase over the next month in response to reminders

Doctors described the changes they had made including improvements in self-care and self-management, reviewing prescribing practices, taking steps to improve interactions with patients and improving note taking.

Half (50%) said they had made changes to their professional development plans as a result of RPR. Most doctors whose RPR reports had identified new areas for development had adjusted their professional development plans to target those areas.

Doctors whose RPR reports included new strengths and new opportunities for development were more likely to have made changes to both their practice and their professional development plans.

1.3.2. Changes reported by doctors in the pilot twelve-month survey

The twelve-month survey results for the early and later cohorts contrasted. The later cohort were far more likely to have made changes to their practice, professional development plans and to recommend RPR to their colleagues.

Comparative information will be available in the next RPR report and may help to understand the factors associated with doctors who report making changes at 12 months.

1.3.3. Factors that may influence the effectiveness of RPR

- Understanding of the purpose of RPR

The number of the participating doctors who had heard of RPR before being contacted to participate appears to be increasing. However, misunderstanding the purpose of RPR is still relatively common, leading to anxiety and reducing the value of RPR for the participating doctor.

- Overall views on RPR

Only one-third (32%) of the doctors expected RPR to be useful, however afterwards a higher proportion (57%) reported that they would recommend RPR to their colleagues.

- Preparation for the visit

More than half of doctors who used the patient and multi-source feedback tools thought they were useful. There were some practical challenges in using the tools and in scheduling the practice visit for some doctors, particularly those in atypical practice.

- The practice visit

Views on the practice visit were generally positive and doctors valued the opportunity for objective input and for self-reflection. However, some doctors emphasised the importance of flexibility in the format of the visit for atypical practice.

- RPR reviewers

It is important that the doctor respects the reviewer as someone with the knowledge and experience to provide input into their practice. Reviewed doctors were often dissatisfied with RPR when they felt they were more experienced than the reviewer, or that the reviewer did not understand their practice.

- The RPR report

Making changes to practice and professional development plans was strongly associated with learning new opportunities for development from the report. Most doctors valued the report, but some commented that they wanted more practical feedback they could act on to improve their practice.

- Follow-up after RPR

Almost all doctors whose reports included new opportunities for development knew what steps they should take to improve their practice. Doctors most commonly discussed their professional development plans with their collegial relationship providers.

1.4 Overview

The RPR design is based on evidence and it is being effectively implemented although there could be more clarity for participants about the purpose of the review. The experience for participants is generally positive and many of the doctors who have completed RPR would recommend it to their colleagues.

Many of the participating doctors have made changes to their practice and their professional development plans. While these are self-reported changes, they provide evidence that for many of the participating doctors RPR is achieving its aims.

Learning about new opportunities for development from the RPR process appears to be closely linked to likelihood to make changes.

1.5 Change in results over time

There are some early indications of improvements over the duration of the evaluation. Twelve months after RPR, higher proportions of the later cohort of doctors (who completed RPR more recently) were positive about RPR and the effect it had on their practice.

Towards the end of 2014, the bpac^{nz} team increased their focus on working with reviewers to develop strategies to help participating doctors to make changes. However, it is too early to tell whether these reflect improvements in the programme. The January 2016 evaluation report will present time-series information from the survey results as well as a comparison between the answers each doctor

recorded in the post-RPR and twelve-month surveys. There should be more than fifty that have completed both by the end of 2015.

1.6 Evaluation next steps

The evaluation will continue to collect data from RPR participants as they receive their reports and twelve-months after they receive their reports. The next evaluation report will be provided in January 2016. The most significant addition to the data for that report will be comparison of post-RPR survey results to twelve-month survey results for doctors who have completed both surveys, highlighting the sustainability of changes over time.

2. Background to Regular Practice Review (RPR)

2.1 Establishment of RPR

One of the key roles of the Medical Council of New Zealand (Council) is to ensure that recertification programmes for all doctors are robust, help assure the public that the doctor is competent and fit to practise, and improve the current high standards of practice of doctors in New Zealand.[2]

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

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

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

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

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

3. The evaluation of RPR

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

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

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

3.1 The evaluation design

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

3.2 Information sources

As for previous reports, this report updates information drawn from interviews and surveys of doctors participating in RPR. Data have been collected at two points in time relative to doctors' participation (invitation sent approximately two weeks after receiving their RPR report and twelve-months later).

- **Two weeks after RPR:** All doctors participating in RPR since June 2014 have been invited to be part of the evaluation through:
  - Two-week online survey: Survey responses from 159 of the 236 (67%) RPR doctors who received their RPR reports between July 2014 and September 2015.
  - Interviews: Doctors who complete the survey can opt-in to follow-up interviews to discuss in-depth their views on RPR. To date, 28 doctors have been interviewed.
  - Interviewed doctors are also asked to provide the contact details of their collegial relationship providers so they can be contacted for an interview. To date, six collegial relationship providers have been interviewed.

- **Twelve months after RPR:** Doctors are invited to participate in the evaluation twelve months after their RPR visit through:
    - Twelve-month online survey: The twelve-month survey was completed by 32 of the 45 early cohort doctors who completed RPR between April and June 2014, giving a response rate of 71%. The twelve-month survey has also been completed by 17 of the 31 (55%) later cohort doctors who also completed the two-week survey in June-September 2014.
    - Interviews: Doctors who complete the twelve-month survey can opt-in to completing an interview. To date, four have been interviewed.

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

3.3 Strengths and limitations at this stage of the evaluation

The evaluation findings are based on the reviewed doctors' self-reported changes. At this initial stage of the evaluation there is no objective information about the extent changes have been made. The evaluation is based on surveys and interviews. Although the response rate from participating doctors was very good there is no information available about how non-responding doctors may differ to responding doctors. At a later stage of the evaluation it will be possible to compare the demographic profile of responding and non-responding doctors based on data provided by bpac^{nz}.

The next evaluation report will focus on the demographic factors of the doctor beyond what is recorded in the survey. Matching survey findings with RPR report results, professional development plan data and other data stored by bpac^{nz} will allow further exploration of differences across doctors with different characteristics.

This report is of doctors included in the general practice cohort. Other professional groups may respond differently to RPR.

4. The participating doctors

4.1 Doctors who completed the online surveys

The doctors who responded to the surveys had been in practice for between 1 and 52 years, but most had less than 10 years' experience. Most of the doctors who had been in practice in New Zealand for fewer than ten years were overseas trained (Table 1).

More than half of the responding doctors completed their training outside New Zealand for both the post-RPR and twelve-month surveys. English was not the first language for nearly one-third of the post-RPR survey doctors.

Table 1. Characteristics of the doctors who completed the post-RPR survey and the twelve-month survey.

Characteristic	Post-RPR survey (n = 159)	Twelve-month survey – early cohort (n = 32)	Twelve-month survey – later cohort (n = 17)
Practicing in New Zealand for:			
• Less than 10 years	45%	47%	17%
• 11-30 years	43%	38%	76%
• 30+ years	12%	16%	6%
Training location:			
• New Zealand	36%	34%	35%
• UK	23%	41%	29%
• South Africa	11%	3%	18%
• Other	20%	19%	18%
• Unknown	9%	3%	-
English not first language	23%	16%	-
Current role:			
• GP	68%	91%	76%
• Other	32%	9%	24%

Roles included in the other or atypical practice category include roles in obstetrics and gynaecology, medical officers, certifying consultants for abortion, primary youth health doctor, skin cancer physician, family planning clinicians, emergency department doctors.

There were differences in the profiles of the doctors completing the post-RPR and twelve-month survey. More of the twelve-month survey respondents were from the UK, and fewer had English as a second language. The twelve-month survey group also included more doctors in GP roles.

These differences in the respondent profiles may contribute to the differences in the results between the two groups. These doctors may also have completed RPR while the process was developing and reviewers were still learning their roles.

5. Changes following participation in RPR

Council's ultimate aim is for RPR to contribute to doctors improving the quality of care they deliver by facilitating professional development.

What's changed since last report

The proportion of doctors who said they had made practice changes remains consistent in the two-week survey (46% compared to 44% in March 2015). Data from the early cohort of the twelve-month survey showed that a smaller proportion of those doctors (who completed RPR in April-June 2014) had made practice changes (19%). A far higher proportion (59%) of doctors in the later cohort who answered the survey had made practice changes.

Summary

Post-RPR

Nearly half (46%) of doctors had already made changes to their practice as a result of RPR and a further 13% intended to make changes.

Doctors described the changes they had made including improvements in self-care and self-management, reviewing prescribing practices, taking steps to improve interactions with patients and improving note taking.

Half (50%) said they had made changes to their professional development plans as a result of RPR. Most doctors whose RPR reports had identified new areas for development had adjusted their professional development plans to target those areas.

Doctors whose RPR reports included new strengths and new opportunities for development were more likely to have made changes to both their practice and their professional development plans.

Twelve-month survey results

The twelve-month survey results for the early and later cohorts contrasted. The later cohort were far more likely to have made changes to their practice, professional development plans and to recommend RPR to their colleagues.

5.1 Post-RPR changes

5.1.1. Post-RPR changes to practice

RPR is expected to contribute to positive changes in practice where the review process identifies opportunities for the participating doctors to improve. Overall, nearly half of the doctors who completed the post-RPR survey said they had already

made changes to their practice as a result of participating in RPR and a further 13% intended to make changes (Figure 1).

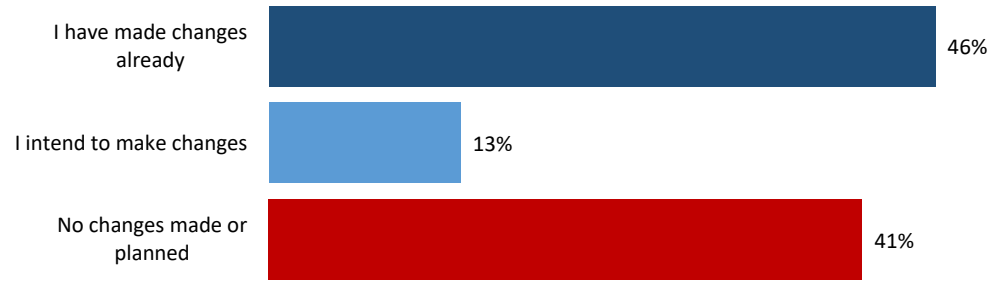

Figure 1. Proportion of survey respondents who had made changes already, who intended to make changes (but had not already done so) and who did not intend to make changes (n = 159).

Around half of the post-RPR survey respondents believed that participating in RPR had improved the care they deliver to their patients and improved their practice in other ways (Figure 2), consistent with results from March 2015.

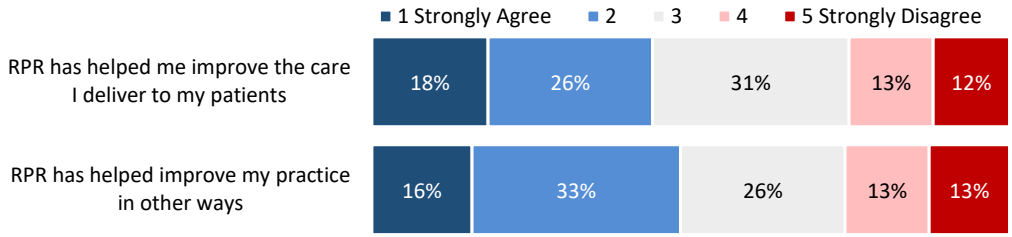

Figure 2. Survey respondents' views on the impact RPR has had on their practice (n = 159).

Examples of changes included specific improvements in consultation style and interaction with patients, improvements to note taking, habits in prescribing and ordering tests, and better use of resources. Some comments from participating doctors are provided in Table 2, though improvements in note taking and recording were the most commonly mentioned. Examples of changes were provided by doctors who were negative about the RPR process as well as those who had positive views.

Table 2. Examples of comments made by doctors who were positive or negative about RPR. Comments describe the changes they have made as a result of participating in RPR. Comments mentioned more often are listed higher in the table.

Positive about RPR	Negative about RPR
Improved notes and record keeping: *Adjusted amount of notation... For example, somewhat increased it, to be more detailed.* *Ensuring appropriate documentation of clinical notes. Going deeper into patient history beyond presenting complaint.* **Changed how consult is managed:** *Tried to change consultation style, trying to prioritize patient questions* **Review prescribing:** *More awareness when ordering investigations like blood tests, and use of antibiotics.* **Communicating more effectively:** *Communicating more effectively with patients who present with lists to ensure priority of needs addressed in 15 minute consultations.* **Give patients more resources (including written instructions and pamphlets):** *Incorporation of more patient information resources.* **Improve e-management:** *Discussed fuller use of med tech e.g. classifications for the whole institution I work for.* **Utilise more resources in practice (online):** *Aim to include more online resources including questionnaires for CME purposes.* **Audit clinical record:** *Starting audit my clinic record and make a protocol to avoid the chance of missing document.* **Improving cultural competence:** *Taking specific interest in Māori and Pacific cultural aspects of patients and trying to integrate them in consultations.*	**Improved notes and record keeping:** *Reviewed notes of applicable patients and recalled for consideration.* **Review prescribing:** *Reviewed prescribing practices.* *Reviewed my prescribing of Augmentin and have looked for other appropriate antibiotic alternatives. I thought this a most valid critique, and when discussed without CME group of some 16 doctors we all accepted we all need to do this.* **Review lab tests ordered:** *I am a bit more critical about which lab tests I order.* **Wash hands more:** *I wash my hands regularly.* **Improve e-management:** *I put extra things at the bottom of my screen.* *Reviewed own practice: reviewed prescribing practices, reviewed notes of applicable patients and recalled for consideration.* **Review testing:** *I have changed my way of approaching thyroid function testing* **Self-care:** *Changes have only been self-care changes - I have created more balance between work and home life.*

5.1.2. Post-RPR changes to professional development

Half of the doctors who responded to the survey had already made changes to their PDPs as a result of their participation in RPR (

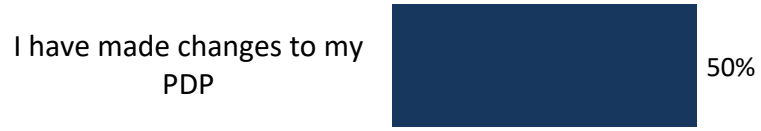

Figure 3). This proportion has remained consistent with results recorded up to March 2015.

I have made changes to my PDP
50%

Figure 3. Proportion of responding doctors who had already made changes to their PDPs as a result of their participation in RPR (n = 159).

One-third (34%) of all surveyed doctors discussed their PDPs with their reviewers. The proportion is consistent with results in earlier reports.

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

- Fine tuning their PDP

Broadening and fine-tuning my CME via the bpac^{nz} system will keep improving my standard of care, keeping me current, interested and stimulated. Benefits to my patients my colleagues and myself.

- Attending training to improve cultural competence

Taking notice of cultural and social aspects of medical practice.

- Entering vocational training

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

- Improving their management of their professional development.

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

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

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

One of the aims of RPR is to improve the way doctors engage with professional development activities and planning. In response to the survey, two-thirds of doctors who completed the post-RPR survey reported that they did not discuss professional

development with their RPR reviewer. Some of those who did discuss professional development with their reviewers reported that the discussion was more administrative (for example what to count as professional development and how to record it) rather than targeting the reviewed doctors' opportunities for development. This was consistent with findings reported in earlier reports.

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

5.1.3. Post-RPR use of e-portfolios

As in earlier results, doctors gave mixed feedback on their use of their e-portfolios. Around half agreed that they updated their e-portfolio at regular intervals and that their e-portfolios were useful tools to improve practice (Figure 4).

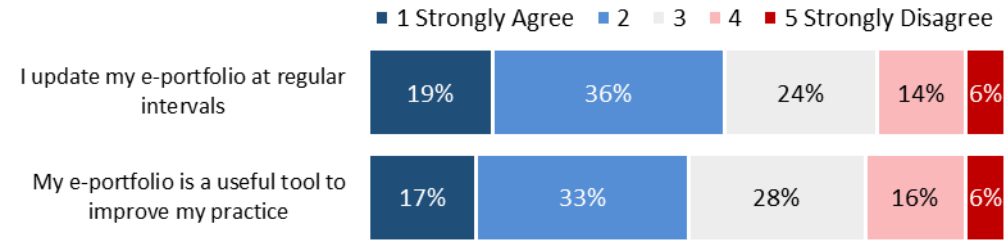

Figure 4. Doctors' views on their e-portfolios (n = 159).

Overall, around half of the responding doctors thought their PDPs were useful tools for improving their practice and planned to adjust them based on the results of RPR. Responding doctors were more likely to do so to target opportunities for development (Figure 5).

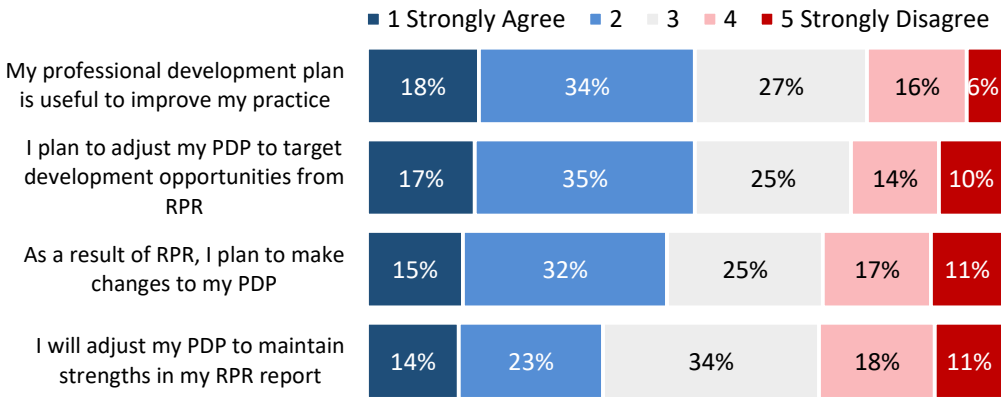

Figure 5. Doctors' views on their professional development plans (n = 159).

Half (53%) of the responding doctors said that RPR identified new opportunities to develop their practice. Of those doctors:

- Most (68%) had made changes to their PDPs (compared to 31% of other doctors)
- Most (81%) planned to adjust their PDPs to target the development opportunities identified in their RPR report (compared to 19% of other doctors).

5.1.4. Post-RPR doctors more likely to report having made changes

It is important to note that the findings in this section rely on doctors self-reporting changes in their practice and their professional development plans. Overall, the results highlight some differences across groups, consistent with results from the March 2015 report.

Examination of these key outcomes from RPR shows that there are some significant differences (others were not statistically significant):

- Doctors who learned about new development opportunities in their RPR reports were significantly more likely to have made practice changes ($t(157) = -6.94$, $p < 0.001$), made changes to their professional development plan ($t(157) = 5.01$, $p < 0.001$) and to recommend RPR to their colleagues ($t(157) = 6.20$, $p < 0.001$).
- Doctors who spoke English as a second language were more likely to agree that they had already made changes to their practice as a result of RPR ($t(157) = -3.35$, $p = 0.01$) and they had made changes to their PDPs ($t(157) = -2.82$, $p = 0.005$).

Years practicing in New Zealand, country of training and current role did not have a significant effect on doctors' likelihood to have made changes, to positively recommend RPR or to have learned about both new strengths and weaknesses in the RPR report.

Table 4 below presents the differences in proportions between the groups of doctors in the survey, though differences not noted above are not significant. As more responses are collected, more differences may emerge or become significant.

Table 3. Proportion of respondents with certain characteristics who had already made changes at the time of the post-RPR survey (n = 159).

	Number of respondents	Have made changes to their PDP	Have made changes to their practice	Would recommend RPR to their colleagues
English as a first language	122	44%	39%	53%
English as a second language	37	70%	68%	68%
Less than 10 years in practice in NZ	71	51%	51%	61%
11-30 years in practice in NZ	69	49%	41%	49%
30+ years in practice in NZ	19	53%	47%	68%
Current role as a GP	108	56%	50%	54%
Other current role	51	39%	37%	63%
Learned no new development opportunities in their report	75	31%	24%	33%
Learned new opportunities for development in their report	84	68%	65%	77%
Trained in NZ	58	47%	40%	47%
Trained elsewhere	101	52%	50%	62%

5.2 Twelve-month survey results

The participants who completed the twelve-month survey have been divided into two groups:

- **Early cohort:** 32 of the 45 doctors received their RPR reports between March and May 2014, earlier in the development of RPR.
- **Later cohort:** 17 of the 31 (55%) doctors who received their reports between June and September 2014, after development of the programme.

5.2.1. Twelve months later: Changes to practice

A smaller proportion of the doctors in the early cohort reported that they had made changes to their practice (Figure 6).

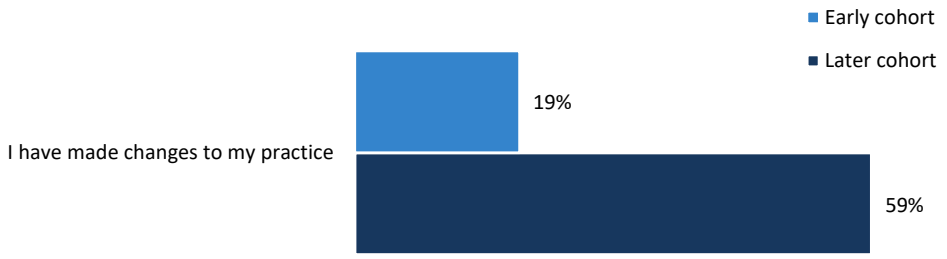

Figure 6. Proportion of twelve-month survey respondents in the early (n = 32) and later (n = 17) cohorts who had made changes already, who intended to make changes (but had not already done so) and who did not intend to make changes.

Similarly, the later cohort was more likely to report that RPR helped them improve the care they provided to their patients (Figure 7).

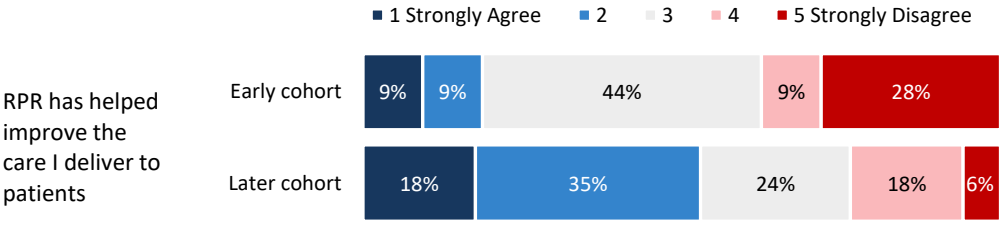

Figure 7. Views of respondents in the early (n = 32) and later (n = 17) cohorts on the impact RPR had on their practice.

In the twelve-month survey, only doctors who were positive about RPR commented on the changes they made to their practice as a result of their participation. Their comments included:

> *Issues noted made me consider how I would practice and then how I did practice in general practice in NZ. Also group versus individual team issues.*
>
> *I'm more careful about documentation in patients' notes,*
>
> *Specifically the personal awareness of varying health literacy; more critical assessment of record keeping.*
>
> *Learn experience from reviewer, it was an opportunity to ask questions that need guidance and compare different way of problem solving in clinic setting.*
>
> *My reviewer helped identify certain communication areas that could be improved. This was subsequently improved on.*

5.2.2. Twelve months later: Changes to professional development

Higher proportions of doctors in the later cohort reported they had made changes to their PDPs, the way they manage their PDPs, and the changes made their PDPs more

useful (Figure 8).

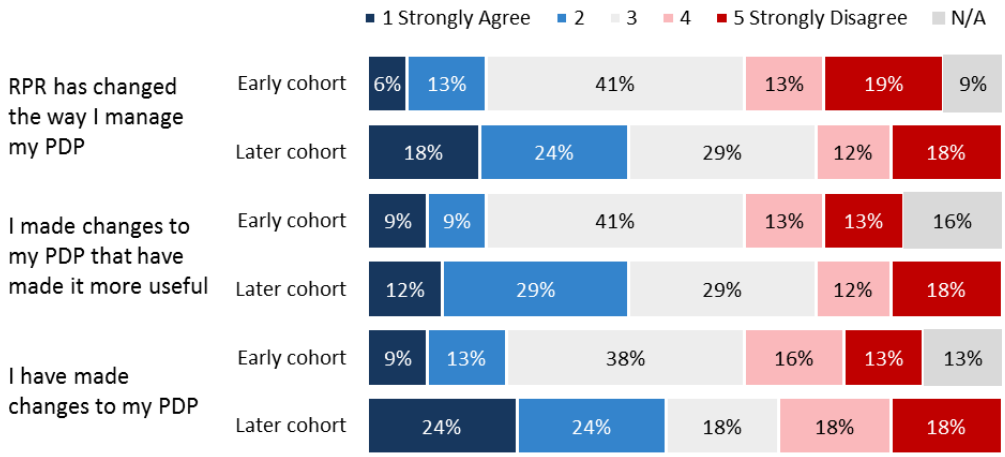

Figure 8. Views of respondents in the early (n = 32) and later (n = 17) cohorts on whether they had made changes to their PDPs as a result of their participation in RPR.

Doctors' comments on the changes they had made to their PDPs as a result of RPR included:

PDP is now more focused.

I am near retirement and had the opportunity to discuss this with an independent colleague and was given some advice on planning for retirement.

I focussed on the specific comments from the examiner instead of searching for philosophical changes.

Probably more reflection thinking about my PDP.

Better understanding about what PDP involves.

5.2.3. Groups of doctors more likely to report having made changes

It is important to note that the findings in this section rely on doctors self-reporting changes in their practice and their professional development plans. At this stage no significant differences have been detected between different groups of doctors' responses to the twelve-month survey in either the early or later cohorts but the sample size is still small.

Table 4 below presents the differences in proportions between the groups of doctors in the twelve-month survey cohorts, though note that at this stage none of the differences are significant.

Table 4. Characteristics of twelve-month survey early (n = 32) and later (n = 17) cohorts who had made changes to their PDPs

	Number of respondents	Have made changes to their PDP	Have made changes to their practice	Would recommend RPR to their colleagues
Early cohort				
English as a first language	27	22%	22%	26%
English as a second language	5	20%	0%	40%
Less than 10 years in practice in NZ	15	20%	20%	33%
11-30 years in practice in NZ	12	25%	17%	17%
30+ years in practice in NZ	5	20%	20%	40%
Current role as a GP	29	21%	21%	28%
Other current role	3	33%	0%	33%
Trained in NZ	11	27%	18%	46%
Trained elsewhere	21	19%	19%	19%
Later cohort				
English as a first language	17	47%	59%	65%
English as a second language	0	-	-	-
Less than 10 years in practice in NZ	3	67%	67%	67%
11-30 years in practice in NZ	13	46%	54%	62%
30+ years in practice in NZ	1	0%	100%	100%
Current role as a GP	13	54%	62%	69%
Other current role	4	25%	50%	50%
Trained in NZ	6	50%	67%	67%
Trained elsewhere	11	46%	55%	64%

6. Factors influencing the effectiveness of RPR

Changes since last report

Feedback on factors influencing the effectiveness of RPR has remained consistent with that received up to the March 2015 report. Doctors are increasingly likely to have heard about RPR from their colleagues or other sources before being invited to participate.

Summary

Understanding the purpose of RPR: The proportion of participating doctors who had heard of RPR before being contacted to participate appears to be increasing. However, misunderstanding the purpose of RPR is still relatively common, leading to anxiety and reducing the value of RPR for the participating doctor.

Overall views on RPR: Only one-third (32%) of the doctors expected RPR to be useful, however a far higher proportion (57%) reported that they would recommend RPR to their colleagues afterwards.

Preparation for the visit: Half of doctors who used the patient (48%) and multi-source feedback (54%) tools thought they were useful. There were some practical challenges in using the tools and in scheduling the practice visit for some doctors, particularly those in atypical practice.

The practice visit: Views on the practice visit were generally positive and doctors valued the opportunity for objective input and for self-reflection. However, some doctors emphasised the importance of flexibility in the format of the visit for atypical practice.

RPR reviewers: It is important that the doctor respects the reviewer as someone with the knowledge and experience to provide input into their practice. Reviewed doctors were often dissatisfied with RPR when they felt they were more experienced than the reviewer, or that the reviewer did not understand their practice.

The RPR report: Making changes to practice and professional development plans was strongly associated with learning new opportunities for development from the RPR report. Most doctors valued the report, but some commented that they wanted more practical feedback they could act on to improve their practice.

Follow-up after RPR: Almost all doctors who had new opportunities for development identified in their reports knew what steps they should take to improve their practice. Doctors most commonly discussed their professional development plans with the collegial relationship providers.

6.1 Understanding the purpose of RPR

The first doctors were invited to participate in RPR in July 2013 so the programme is relatively new. In the early stages of the evaluation, many of the interviewed doctors knew nothing about RPR until they were invited to participate.

As the evaluation has progressed and more doctors have participated in RPR, it appears that more of the doctors had heard about RPR or discussed it with a colleague who had participated.

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

Doctors are provided with information about RPR in the lead up to the visit. However, even doctors who had heard about RPR or discussed it with colleagues often held misconceptions about its purpose. Most often they saw RPR as a pass/fail audit of their practice, rather than a process focusing on improving quality of care through facilitating professional development. Doctors who saw RPR in this way were more likely to raise two issues:

- **Inequity:** They should not have to participate in this process when other doctors did not have to. For example, one said:

  My real concern is the fundamental basis that the Council uses to require this kind of assessment. That is that they subscribe to this pecking order system that if you are vocationally registered you are a better doctor than a GP who is not. So there is a sort of tiering in place. I fundamentally disagree with that. So do many of my peers. I object to this whole process in the first place.

- **Anxiety:** Feelings of worry and anxiety about having their practice examined and the risk to their practice and wellbeing if they do something wrong or do not perform for the reviewer (sometimes even called the examiner) on the day of the practice visit. For example, one said:

  I thought it would be more for the criticism rather than positive feedback. My impression was that they were there to observe you and criticise you not so much to improve you but to give feedback to Inpractice that this person is worthy of a medical licence. Not there to teach new tricks but just to observe and give feedback on which ones are okay or not okay.

The risk is that doctors who see RPR in this way and are not used to performance appraisal could see RPR as a threat rather than an opportunity to learn and to improve (Wallis, 2014). In a qualitative study, Pelgrim et al. (2012) found that apprehension about being observed and receiving feedback proved to have a powerful negative effect on feedback for postgraduate general practice medical trainees.

While some doctors still held this misconception after their experience with RPR, others realised the purpose after their visit and receiving their report.

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

Increasing understanding could increase satisfaction amongst the few doctors who were not positive about RPR after their reviews. The purpose of RPR will become better and more widely understood as it becomes more embedded. There may be opportunities to increase understanding of the purpose of RPR for doctors as they are invited to participate, and among the medical community as a whole. Some interview participants suggested a call from the reviewer in advance and a more in-depth discussion of the purpose of the review as well as practical concerns could have helped them.

6.2 Overall views on RPR

Overall, one-third of doctors who completed the RPR-post survey thought that RPR would be useful or very useful before they took part (

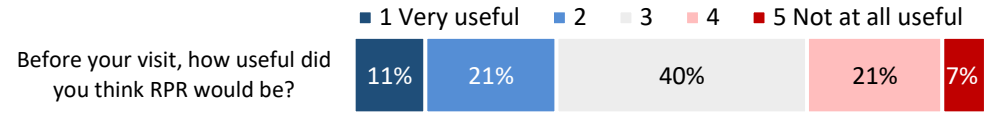

Figure 9).

1 Very useful
2
3
4
5 Not at all useful
Before your visit, how useful did you think RPR would be?
11%
21%
40%
21%
7%

Figure 9. Views of doctors who completed the post-RPR survey on how useful they thought RPR would be before their practice visit (n = 159).

Figure 10 provides examples of why doctors thought the visit would be useful or not useful. Those who anticipated the visit would be useful welcomed the opportunity to discuss and receive feedback on their practice. Comments from those who thought RPR would not be useful reflect misunderstandings of the purpose of RPR as discussed above.

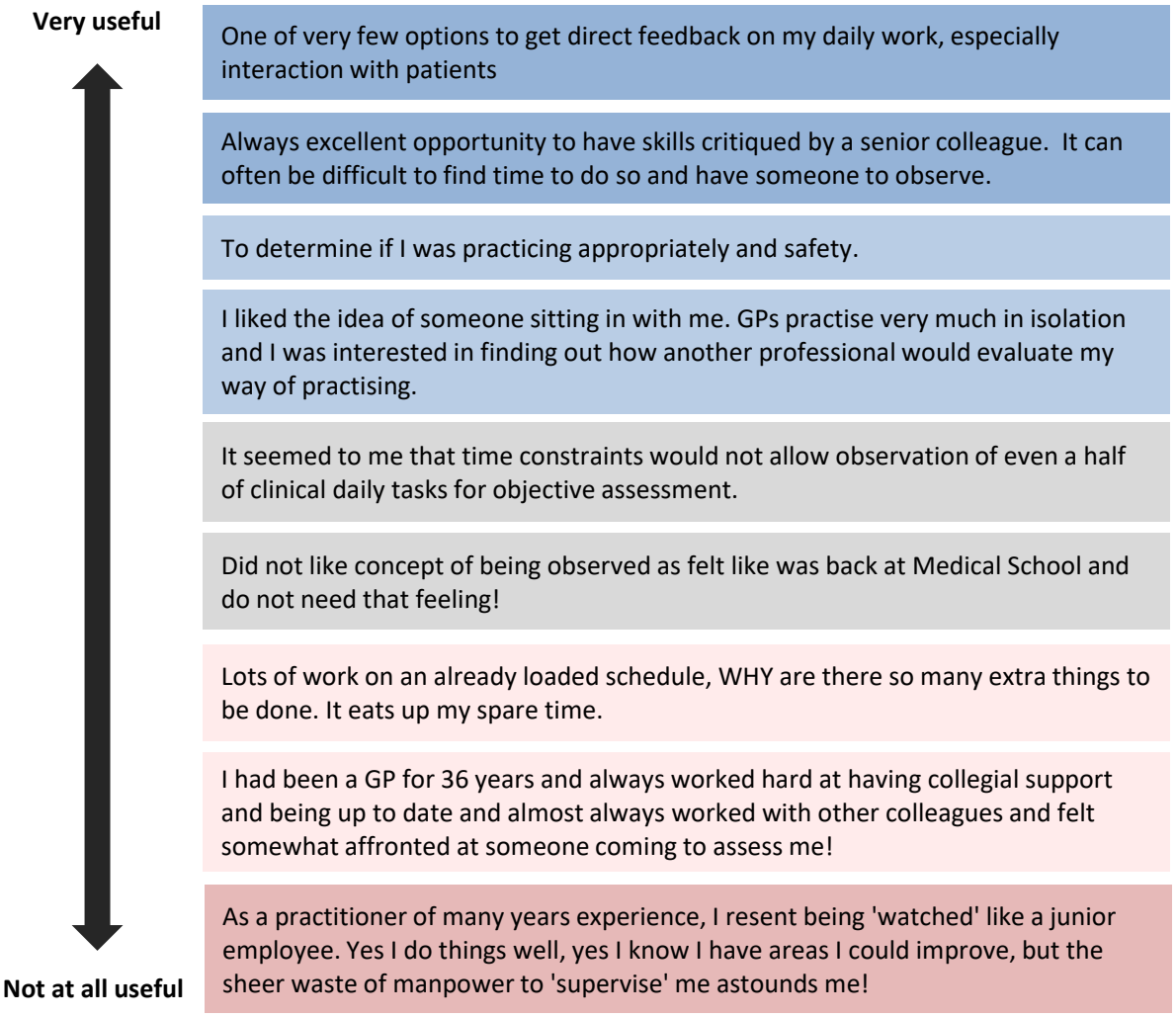

Figure 10. Examples of doctors' reasons for believing RPR would be useful or not useful before their participation.

Doctors' responses when asked what they hoped to get out of participating in RPR were similar. Some doctors hoped for constructive feedback as a result of the review process and hoped to improve their practice through the input of another doctor.

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

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

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

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

In the post-RPR survey, more than half (57%) of the doctors agreed that they would positively recommend it to their colleagues (

Figure 11). As in other measures of RPR's effectiveness, the later cohort were more positive than the early cohort.

Figure 11. Post-RPR (n = 159) and twelve-month early cohort (n = 32) and later cohort (n = 17) survey respondents' agreement that they would positively recommend RPR to their colleagues.

Doctors in the later cohort of the twelve month survey were more positive about the usefulness of RPR in hindsight (

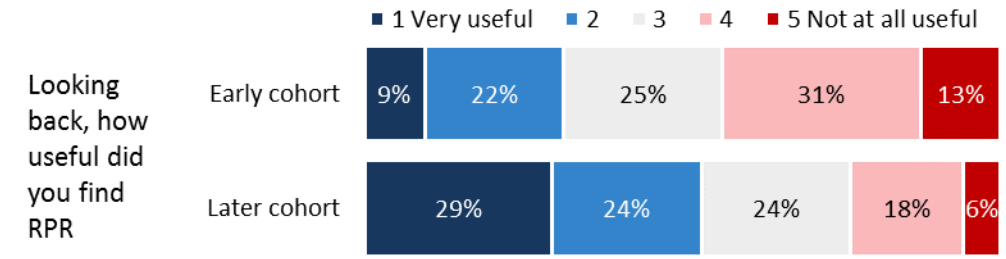

Figure 12).

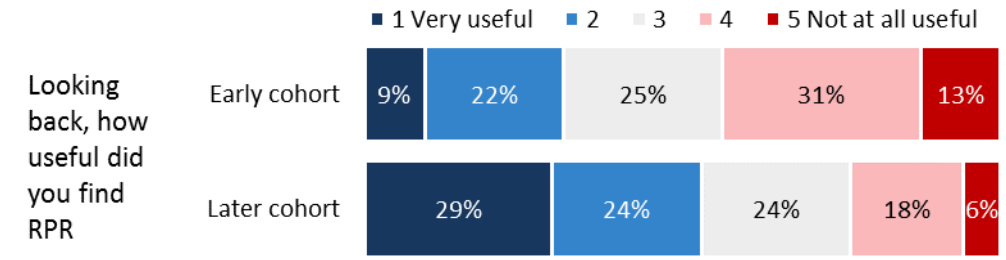

Figure 12. Views of doctors in the twelve-month early cohort (n = 32) and later cohort (n = 17) on the usefulness of RPR in hindsight.

6.3 Preparation for the visit

Preparing for RPR requires some action on the part of participating doctors. They must:

- Schedule an appropriate day for the practice visit with bpac[nz]
- Complete the multi-source and/or patient feedback processes
- Arrange the practical aspects of the practice visit, including making appointments with patients and obtaining their consent for the reviewer to observe the appointments.

Doctors were positive about the administration of the visits, including the scheduling and contacts with bpac[nz].

[bpac[nz]] staff member was very easy to deal with.

The proportion of survey respondents who completed the patient feedback increased from 52% in March 2015 to 62% in September 2015. Overall, excluding those who did not use the feedback tools, doctors held similar views about the two tools with around half agreeing that they provided useful information (

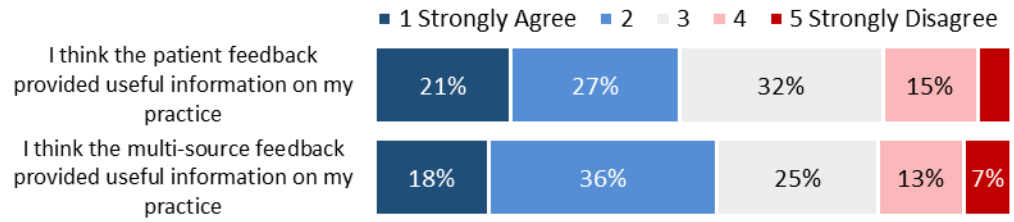

Figure 13).

1 Strongly Agree
2
3
4
5 Strongly Disagree
I think the patient feedback provided useful information on my practice
21%
27%
32%
15%
I think the multi-source feedback provided useful information on my practice
18%
36%
25%
13%
7%

Figure 13. Survey respondents' views on whether the patient (n = 94) and multi-source feedback (n = 134) tools provided useful information about their practice.

An average of 35 patient feedback forms were completed for the 147 doctors who used the patient feedback tool. The overwhelming majority of ratings were positive. For example, only four out of the 147 RPR doctors had any patients give them a 'poor' rating when asked 'how good was your doctor at providing or arranging treatment for you today?' For three of the four doctors, only one patient gave them a poor rating and the fourth doctor had two patients give them a negative rating.

The questions that most commonly had any negative responses across all patients were confidence the doctor will keep information confidential (39 doctors with any negative responses), honesty and trustworthiness of the doctor (32 doctors)

explaining your condition and treatment (20 doctors). These represent a very small proportion of the total number of patient feedback responses. Overall, only 42% of the doctors had any patients give a negative rating for any of the questions asked.

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

Some of the doctors who reported that the patient and/or multi-source feedback tools were not useful may have had difficulty completing them. Comments from doctors who had difficulty with them focused on:

- Not understanding what they were required to do.

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

- The questions being unsuitable for their particular practice as it was not similar enough to standard general practice. For example, a travel medicine doctor who had long, one-off appointments with no follow-up appointments felt most of the patient feedback questions were not relevant for their patients.

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

- Not having enough colleagues in regular contact and/or not having enough established patient relationships. This was most often an issue for 11 of the 120 doctors who completed the post-RPR survey who were working in locum positions. Other reasons for having difficulty meeting the required numbers were being new to practicing in New Zealand and not having much contact with other health professionals in their role beyond referral letters.

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

Some doctors were concerned about the practical requirements of the practice visit. Arranging to see a sufficient number of patients on the day of the practice visit was a challenge for some who had practices different from standard general practice. Examples included doctors who:

- Had longer appointment times (sometimes over an hour), for example travel medicine, psychological medicine and integrated medicine doctors
- Did not have set appointments but worked with patients as they came in
- Worked in multiple locations within a normal work day.

It is important that the RPR process and the reviewers are flexible enough to manage these differences. In most cases, the reviewers handled these situations well on the day and showed enough flexibility. One reviewer said:

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

Doctors appeared to be most positive where they had the opportunity to discuss why their practice was different in the preparation stages before the visit so that they could be confident that the visit would run smoothly. If they raised issues and did not feel that they were heard, or that changes were being made to the normal process to accommodate their practice, they often held more negative views of RPR as a whole.

For example, in one case a doctor raised concerns about the effect of the practice visit on their patients. The doctor felt that the process of obtaining consent from the patient for the reviewer to observe an appointment, and having the reviewer observe an appointment, posed risks to his patients' wellbeing. He raised these concerns but did not feel that any changes were made in response. Following the visit, the doctor felt that RPR had resulted in negative effects for several of their patients.

6.4 The practice visit

RPR aims to contribute to continuous improvement in doctors' practice and in their approach to professional development. Doctors' feedback highlighted the importance of the practice visit as a quality improvement tool that prompted self-reflection. Having an objective view on their practice enabled self-reflection and was of benefit in itself.

Post-RPR survey respondents were generally positive about their experience of the practice visit with only a small proportion disagreeing that the practice visit was a positive experience (

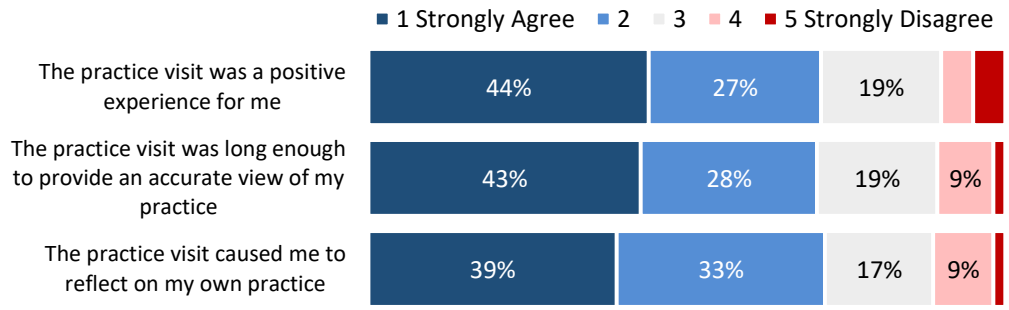

Figure 14). Results remain consistent with those from earlier reports.

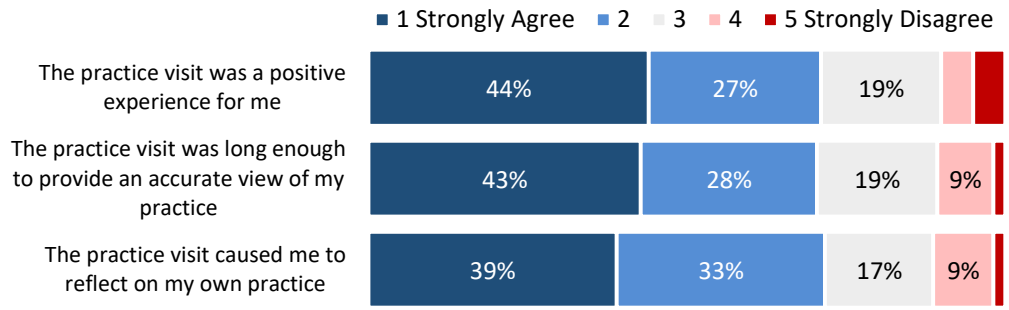

Figure 14. Survey respondents' views on their experience of the RPR practice visit (n = 159).

Doctors in general practice interact with patients on a 1:1 basis and rarely have opportunities for independent observation or objective feedback. Doctors in group practice may be aware of the standard of their colleagues' work but there are often no mechanisms for formal feedback. For many of the reviewed doctors, having an objective view of their practice from a knowledgeable and respected colleague was valuable even to confirm that they were doing a good job.

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

Doctors' comments about the most valuable aspects of practice visits focused on appreciation of the opportunity to receive feedback on their practice and to have a discussion with the reviewer. The positive reinforcement increased the doctors' confidence in their practice. Practical tips were also noted as helpful. Collegiality, seeing that the reviewers understood the doctors' practice and receiving constructive criticism were also commonly cited as valuable.

Examples of doctors' comments about the most valuable aspects of the practice visits are provided alongside their rating of whether they agreed the practice visit was a positive experience for them (Figure 15).

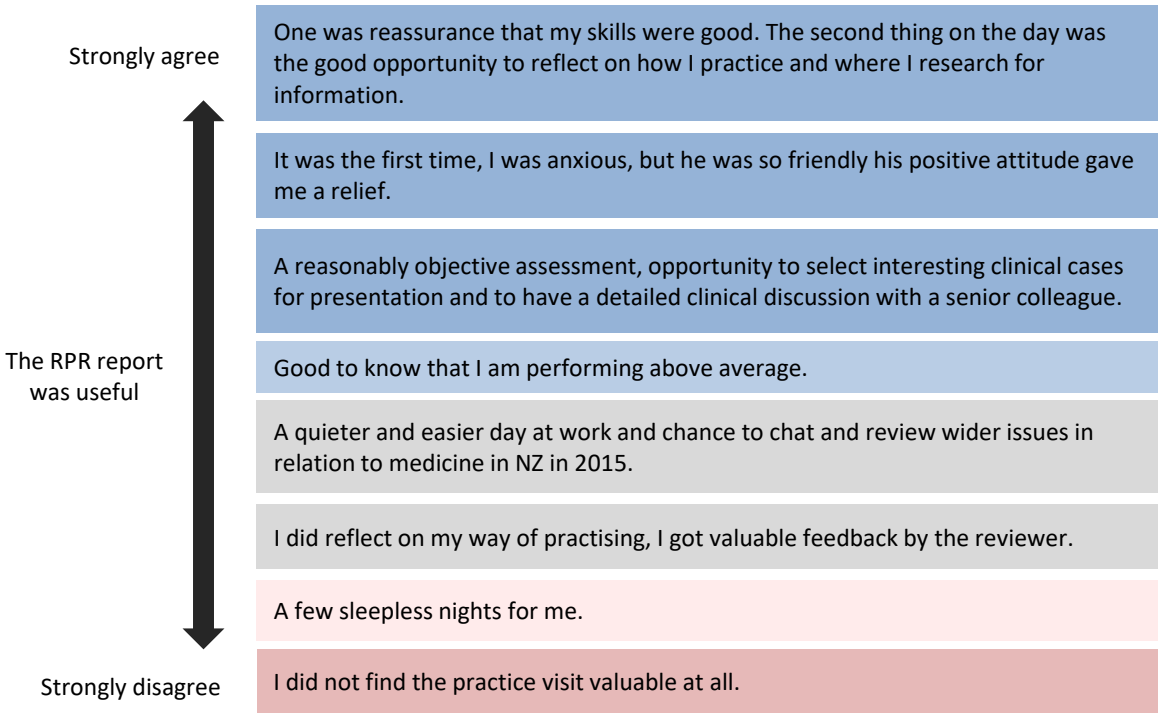

Figure 15. A selection of doctors' comments on the most valuable aspects of the practice visit sorted by whether they thought the practice visit was a positive experience.

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

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

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

Miller and Archer (2010) carried out a systematic review of studies testing the educational or performance effects of workplace based assessments for doctors. Their findings, primarily based on comparative descriptive or observational studies,

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

O'Brien et al, (2008) conducted a systematic review on the effectiveness of educational outreach visits to healthcare professionals, which were defined as personal visits by a trained person to health professionals in their own settings targeting a specific outcome. The authors concluded that outreach visits had small but consistent effects on prescribing but the effect of outreach visits on other types of professional performance was found to vary between studies from small to modest improvements. The reasons for differences could not be explained.

The findings of Jamtvedt et al. (2012) suggest that a senior colleague, respected by the doctor, is ideally placed to provide effective feedback. CRPs give the doctors feedback on a more regular basis than RPR occurs. As noted in section 5.1, the reviewed doctors most commonly CRPs. There was variation in the quality of relationships described by the reviewed doctors and by the CRPs interviewed. In some cases, the relationships involved a combination of informal discussion (by phone, email or in-person) of particular cases, formal and regular meetings to discuss the doctors' practice and involvement in peer review networks. Such relationships appeared to be of substantial value in supporting the doctors' professional development and the CRPs felt that they were contributing to improvements in the doctors' practice. In other cases, the CRP relationship was not formal and there were barriers to open and honest communication, for example an employer-employee dimension. Providing feedback and support that leads to change is a skilled process and not all CRPs may have the appropriate skills or experience to do so.

6.4.1. Least valuable aspects of the practice visits

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

- Disruption to the doctor's normal working day. This was a particular issue for locum doctors. One commented that she felt she was not fulfilling her contractual obligations on the RPR day as she was not able to see as many patients as usual. The time involved was also a frustration where a practice had multiple visits in a short time period.

- Some doctors expected RPR to focus on their clinical skills, for example their clinical reasoning, and were frustrated when feedback focused on process (for example note keeping).

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

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

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

6.5 The RPR reviewers

The reviewers play a crucial role in the RPR process. They must have the appropriate skills to work with the reviewed doctor, gain their respect and deliver feedback in a way that is most likely to lead to improvement. Effective feedback is feedback in which information on previous performance is used to promote positive development. It should be planned, delivered in an effective manner and be incorporated into the learning process by relating it to learning goals and plans for improvement (Archer, 2010). Ensuring that the reviewers are trained to deliver feedback effectively on the day is important. Some doctors highlighted the discussion with the reviewer about findings as one of the most valuable aspects of RPR and doctors made negative comments when they found feedback in the report that they had not already discussed with the reviewer. Ensuring that the feedback is given in an effective manner and that the next step, how it can be incorporated into professional development plans, is discussed could be a way to increase the impact of RPR.

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

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

Most doctors felt that the reviewer demonstrated appropriate skills to evaluate their practice (

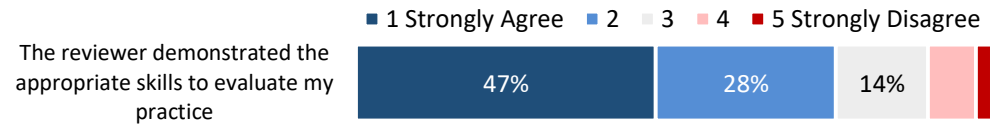

Figure 16), consistent with results from the March 2015 report.

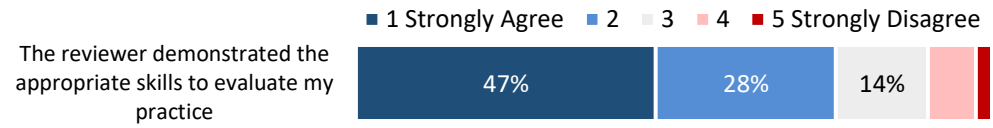

Figure 16. Responding doctors' views on the reviewers' skills (n = 159).

The match between the reviewer and the reviewed doctor in terms of seniority and area of practice were often mentioned by survey and interview respondents as reasons for their satisfaction or dissatisfaction. As noted above, feedback is most effective when it comes from a senior colleague so it is important that the reviewed doctor respects the reviewer. Where the reviewed doctor did not see the reviewer as suitable there was often dissatisfaction with the experience as whole. The opposite was also true. For example:

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

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

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

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

Having a senior reviewer was also valued.

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

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

> *The reviewer kept sighing during the consultations which intrusive.*

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

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

6.6 The RPR report

The RPR report is the formal mechanism for providing information back to participating doctors. The majority of survey respondents felt that the RPR report was useful and accurately described their practice. More than half reported their RPR report identified new opportunities to develop their practice (Figure 17).

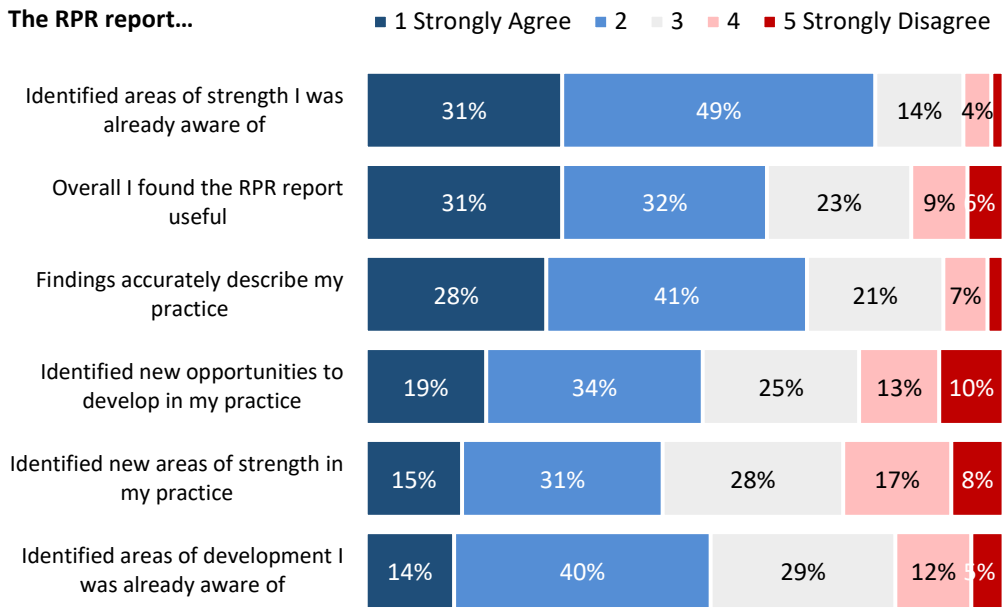

Figure 17. Survey respondents' views on their RPR reports (n = 159).

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

Very small proportions of doctors received unsatisfactory ratings for any of the RPR report sections, and all unsatisfactory ratings were for record keeping and their competence in navigating and utilising the PMS (1-3% unsatisfactory). No doctors received a negative ratings for fitness to practice, with just 1% receiving a neutral rating. Figure 18 shows the proportion of doctors who received a 'superior' rating (the nine point scale is divided into three sections: unsatisfactory, satisfactory and superior).

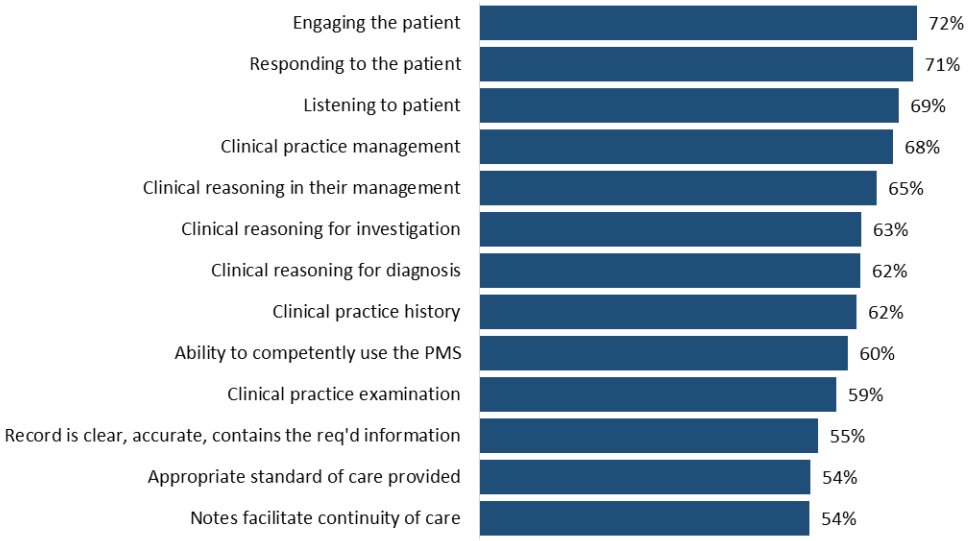

Figure 18. Proportion of doctors receiving the 'superior' rating for each of the RPR report rating questions (n = 318).

Encouraging doctors' development requires that they be made aware of opportunities for developing their practice as well as what steps they may be able to take to respond to those opportunities. Overall, half (53%) of the responding doctors said that RPR identified new opportunities to develop their practice.

Some doctors wanted more guidance on how they could improve their practice. Doctors who learned about new development opportunities in their reports were far more likely to have made changes to their practice and their professional development and to recommend RPR to their colleagues. In interviews, even doctors who received very positive ratings wanted to receive some practical advice. A selection of doctors' comments on the most useful and least useful aspects of their RPR reports are presented in Figure 19.

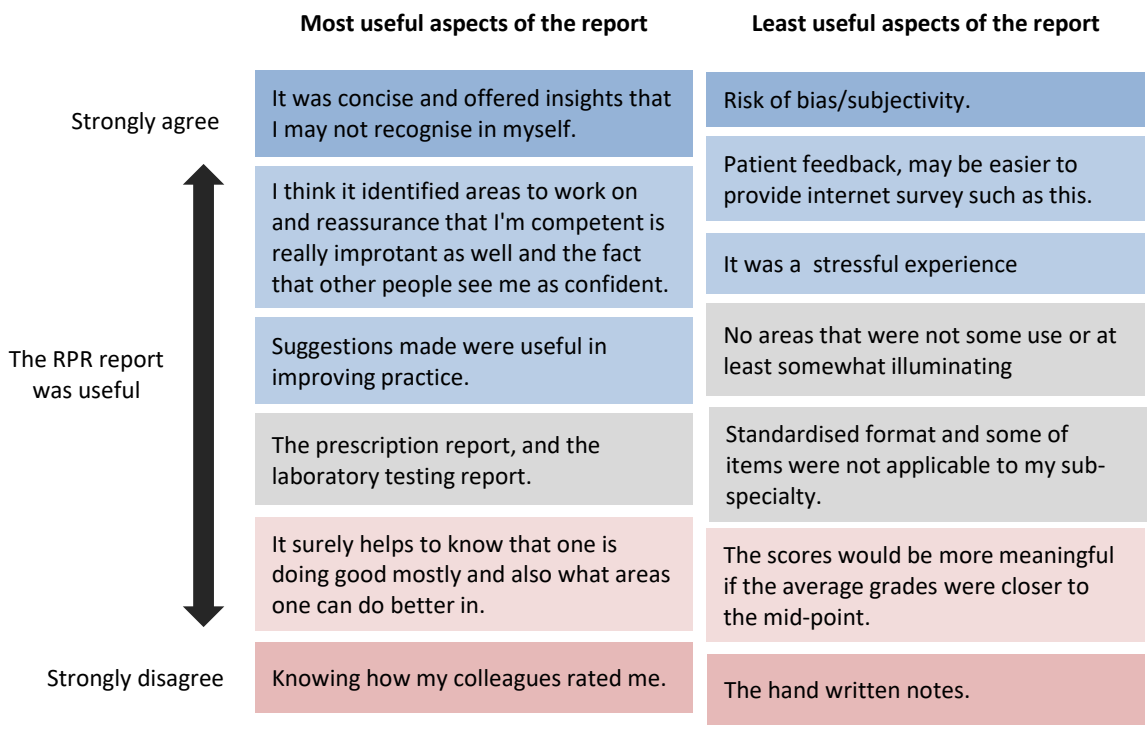

Figure 19. Examples of doctors' comments in the post-RPR survey on the most and least useful aspects of the RPR report.

6.7 Follow-up after the review

As noted above, half (53%) of the responding doctors said that RPR identified new opportunities to develop their practice. Almost all (85%) reported that it was clear what action they needed to take to address the development opportunities identified in the report. The mechanisms in place to support doctors in their development include professional development plans and relationships with their CRPs.

In addition, some reviewers wanted an opportunity to contact the doctors again to follow-up on the feedback they provided doctors. This could be an opportunity to offer support, and to check that action had been taken to address the identified opportunities for development.

Some of the reviewed doctors also wanted follow-up with the reviewer, particularly where they were surprised by the comments of the reviewer or where they disagreed with the comments. Suggestions usually focused on a phone call to minimise the burden on both the doctor and the reviewer.

6.7.1. Professional development plans

It is expected that doctors will be able to modify their professional development plans to address the opportunities for development identified by RPR. Doctors responding to both the twelve-month and the post-RPR surveys most often discussed their professional development plans with their collegial relationship provider (Table 5).

Doctors responding to the post-RPR survey were more likely to report discussing their PDPs with their CRP than those in the early cohort of the twelve month survey.

Table 5. Proportion of doctors who discussed their professional development plans with different groups. Note that doctors were able to select more than one option.

Person PDP discussed with	Post-RPR (n = 159)	Twelve-month Early cohort (n = 32)	Twelve-month Later Cohort (n = 17)
Collegial relationship provider	66%	44%	71%
Other colleagues	38%	22%	53%
RPR reviewer	34%	3%	6%
Employer/manager	16%	22%	29%
Other	13%	3%	6%

6.7.2. The Collegial Relationship Provider

CRPs play an important role in providing feedback and supporting the professional development of general scope doctors, including those participating in RPR. CRPs are required to be:[3]

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

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

- random auditing of a specified number of clinical records in any one calendar year and giving feedback on areas for improvement
- observing a specified number of consultations in any one calendar year and giving feedback on areas for improvement

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

- helping the doctor in any other mutually agreed way to enhance his or her practice skills and personal growth.

When doctors are sent their RPR report, they are recommended to discuss the report with their collegial relationship provider. Two-thirds (66%) of the doctors who responded to the post-RPR survey had discussed the PDPs with their CRPs. The two groups of doctors responding to the twelve month survey differed. Smaller proportions of doctors in the early cohort had spoken to each of the different groups of people about their professional development plans (refer to Table 5).

Interviews highlighted variation in the effectiveness of the CRP relationship. Some were positive, constructive and were utilised regularly as intended. For example, one doctor had a relationship with a senior colleague who used to work in the same practice. They participated together in a registered peer review group, met approximately once every two months for formal CRP meetings including discussions of professional development and more frequently exchanged informal emails about individual cases or developments in their field of practice. The CRP believed she contributed to improving the doctor's practice:

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

In a contrasting example, the CRP of one doctor had seen them three times over the last 12 months. When they met up they mostly talked about how things are going and various cases which generally leads to discussing medical principals and drugs. The last time they met they did discuss the RPR feedback but it was mostly positive. Because the CRP is a surgeon and the other doctor is a locum it was hard to see each other and the fact that they worked in very different roles made it difficult for the CRP to be an effective mentor. The CRP thought that this could only happen when you work closely with a colleague. The CRP also thought older doctors tended to not be as accepting of CRP relationships. The CRP thought their relationship with the doctor had probably not made any 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.*

Building up the role of the CRP in following-up on the RPR findings may be one option to increase the amount of follow-up from CRP. The CRP is involved in the review process and most CRPs interviewed had discussed the reviewed doctors' RPR reports with them. This change alongside strengthening the CRP role could be an opportunity for development though questions about training and funding for this would need to be addressed.

6.7.3. Timing of next RPR visit

Many doctors commented on the frequency of the RPR visits. Doctors' views were mixed on whether the current three-year interval was the best option. Most often, they suggested that a four or five year interval would be preferable except where concerns were raised about the doctors' practice.

> *I think that the term of three years is too short. Perhaps a variable term might be in order so that problems needing addressing in short term be addressed and others that could be looked at in say five years are left.*

> *While I think it is reasonable to have to undergo it once, the idea of all GPs having to go through this every three years seems an enormous waste of time and money, when resources could be better targeted at doctors who have been identified as needing, or have asked for, help. I have no problem with the e-portfolio requirements which are not excessive. I personally would rather do an MCQ test every three years to gauge my own knowledge and identify areas of weakness.*

7. Conclusion

7.1 Overview

The RPR design is based on evidence and it is being effectively implemented although there could be more clarity for participants about the purpose of the review. The experience for participants is generally positive and many of the doctors who have completed RPR would recommend it to their colleagues.

Many of the participating doctors have made changes to their practice and their professional development plans. While these are self-reported changes, they provide evidence that RPR is achieving its aims for many of the participating doctors.

Learning about new opportunities for development from the RPR process appears to be closely linked to likelihood to make changes.

7.2 Change in results over time

There are some early indications of improvements over the duration of the evaluation. Twelve months after RPR, higher proportions of the later cohort of doctors (who completed RPR more recently) were positive about RPR and the effect it had on their practice.

Towards the end of 2014, the bpac^{nz} team increased their focus on working with reviewers to develop strategies to help participating doctors to make changes. However, it is too early to tell whether these reflect improvements in the programme. The January 2016 evaluation report will present time-series information from the survey results as well as a comparison between the answers each doctor recorded in the post-RPR and twelve-month surveys. More than fifty doctors should have completed both surveysbby the end of 2015.

7.3 Evaluation next steps

The evaluation will continue to collect data from RPR participants as they receive their reports and twelve-months after they receive their reports. The next evaluation report will be provided in January 2016. The most significant addition to the data for that report will be comparison of post-RPR survey results to twelve-month survey results for doctors who have completed both surveys, highlighting the sustainability of changes over time.

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Appendix One: Logic Model and Evaluation Framework

Long-term outcomes

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

Medium-term outcomes

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

Short-term outcomes

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

Outputs

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

Activities (inputs)

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

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

Evaluation Framework

Evaluation question	Indicator	Data Source
RPR processes		
What is included in the RPR process?	• Description of RPR tools and processes	• Interviews with bpac[nz] • Review of RPR online processes
Participating doctors experiences of taking part in RPR		
How easy or difficult do doctors find completing the pre-review documents?	• Doctors understand the pre-review requirements • Doctors' opinions on obtaining multisource or patient feedback • Doctors' opinions about the ease or difficulty of preparing their e-portfolios in preparation for the review	• bpac[nz] data – numbers selecting different multi-source or patient feedback options and changes over time. • Online survey of doctors • Interviews with doctors
What do participating doctors think about the practice visit?	• Doctors report the practice visit was a positive experience • Doctor's views on working with one reviewer (compared with two reviewers for Colleges reviews) • Doctors report the practice visit provided them with opportunities to reflect on their practise -75% rate the visit as useful or very useful to them	• bpac[nz] data – numbers of visits on the planned date, changed dates (doctor or reviewer) • Online survey of doctors • Interviews with doctors
How useful did participating doctors find the RPR report?	• Doctor's assessments of the usefulness of the RPR reports -75% rate the report as useful or very useful to them • The extent doctors consider the RPR reports reflect their own views on their practise • Doctors consider the report provides them with 'new' insights into how they could improve their practise	• Online survey of doctors • Interviews with doctors
Do doctors respond to RPR information?	• Doctors report that the RPR helps them identify areas of strengths in their practice • Doctors report that the RPR helps them identify areas for improvement	• 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 practise as a result of their role as reviewers	• Interviews with reviewers • Online survey of reviewers
What do reviewers think about the extent RPR doctors use the RPR report to change their practise?	• The extent reviewers engage with collegial relationship providers • The extent doctors discuss PDP with the reviewers • Reviewers' opinions on the impact of RPR on facilitating changes in practise	• Reviewer interviews • Reviewer survey • Collegial relationship provider interviews
Other stakeholders' experiences of RPR		
Is the RPR process meeting the expectation of the Medical Council?	• The Medical Council considers the RPR process is developing in a satisfactory manner	• Interviews with the Medical Council
What is the role of the collegial relationship provider in assisting RPR doctors to develop PDPs in response to RPR?	• Collegial relationship providers' descriptions of their roles and perceived effectiveness • Doctor's description of how they worked with their collegial relationship providers	• Interviews with RPR doctors • Interviews with collegial relationship providers • Survey of RPR doctors
RPR achievements		
Do participating doctors assess the RPR process as useful in developing their practise?	• 80% of doctors rate their understanding of the RPR process as good or very good	• Online survey with doctors • Interviews with doctors
What changes do doctors make/ or plan to make as a result of the RPR report?	• Doctors use RPR to plan PDP and participate in planned PD activities • Doctors report changes to their practice • Tracking of any 'measurable' changes identified by individual doctors	• 12 month online survey of doctors • 12 month interviews with doctors

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