Malatest International

Evaluation report: February 2016

Evaluation of the Regular Practice Review Programme

Table of contents

Definitions and abbreviations **3**

Executive Summary **4**

About RPR 4

About the evaluation 4

Changes to practice 5

Changes to professional development 6

Factors with the potential to influence the effectiveness of RPR 6

The reviewers 7

Overview 7

Evaluation next steps 8

1. Background to Regular Practice Review (RPR) **9**

1.1 Establishment of RPR 9

2. The evaluation of RPR **10**

2.1 The evaluation design 10

2.2 Information sources 10

2.3 Strengths and limitations at this stage of the evaluation 11

3. The participating doctors **12**

4. Changes following participation in RPR **13**

4.1 Changes in practice 14

4.2 Changes to professional development 20

5. Factors with the potential to influence the effectiveness of RPR **24**

5.1 Understanding the purpose of the RPR 24

5.2 Visit preparation and logistics 27

5.3 Overall impressions 28

5.4 RPR tools and components 29

5.5 The RPR report 33

5.6 Follow-up after the review 36

6. The RPR Reviewers **41**

6.1 The 2014 reviewer survey 42

6.2 Participating doctors' perspectives 42

6.3 Reviewer training and preparation 44

6.4 Reviewer workload 44

6.5 Reviewers' perspectives on doctors' reactions to RPR 45

6.6 The practice visit and feedback to doctors 46
6.7 Views on RPR's effectiveness 47
6.8 Benefits for reviewers 48
6.9 RPR reviewer suggestions for improvement 48
6.10 Variation in response to reviewers 49
7. Conclusion 51
7.1 Evidence based 51
7.2 Doctors are reporting making changes 51
7.3 Change over time 52
7.4 The reviewers 52
7.5 Strengthening the programme 53
7.6 Evaluation next steps 53
8. References 54
Appendix One: Logic Model and Evaluation Framework 55

Definitions and abbreviations

Abbreviation	Definition
bpac^{nz}	Best Practice Advocacy Centre, responsible for delivering RPR.
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 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.

Council's aim is that all doctors (except those in vocational training) will have the opportunity to undertake a form of regular practice review (RPR) 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 medical 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.

RPR involves:

- Pre-visit: Review of the doctor's professional development ePortfolio, prescribing and laboratory test reports, 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.

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

To date 439 doctors have completed RPR. All 301 who completed RPR since the RPR evaluation began in June 2014 have been invited to participate in the evaluation.

About the evaluation

The Regular Practice Review (RPR) evaluation provides mid-year and end of year evaluation reports. Previous reports include:

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

This report updates the mid-year 2015 report provided in October 2015. As for previous reports, this report updates information drawn from interviews and surveys of doctors participating in RPR and provides an overview of findings to date. Information sources for the evaluation are summarised in the table below.

Data from:	Doctors	Reviewers
Online surveys	• Post-RPR survey of participating doctors (194 of 301, 65%) • Twelve-months after RPR (36 of 60, 60%)	• 2014 survey of reviewers about their role (19 of 19, 100%) • 2016 survey of reviewers about their role (22 of 33, 67%)
Interviews	• Post-RPR interviews with participating doctors (39) • Interviews with doctors approximately 12 months after RPR (6)	• 2014 interviews with reviewers about their role (6) • 2016 interviews with reviewers about their role for RPR (9)
	Other sources of data	
bpac^{nz} data	• Patient feedback forms on doctors completed before the RPR visit (7,961) • Feedback from the colleagues of participating doctors completed before the RPR visit (2,803) • RPR report results for all participating doctors (439)	
Other	• A review of the literature about professional development	
	• Interviews with collegial relationship providers (7)	

All doctors included in this report who completed the twelve-month survey also completed the post-RPR survey.

Since the last report, there have been:

- 49 post-RPR survey responses and six interviews, conducted shortly after the RPR.
- 19 twelve-month survey responses and one interview, conducted approximately one year after the RPR.
- The second reviewer survey.

Changes to practice

Overall, nearly half (48%) 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. Around half of the post-RPR survey

respondents agreed that participating in RPR had improved the care they deliver to their patients and improved their practice in other ways.

Most doctors continued to report changes in practice at twelve-months. Smaller but still substantial proportions thought RPR had helped improve the care they delivered to their patients (33%) and/or had improved their practice in other ways (39%).

Examples of changes reported by doctors included improvements in consultation style and interaction with patients, improvements to note taking, habits in prescribing and ordering tests, and better use of resources. Improvements in note taking and recording were the most commonly mentioned. The types of changes doctors reported have remained consistent over time.

Doctors who learned new development opportunities from RPR were more likely to have made changes to their practice, to their professional development plan and were more likely to recommend RPR.

Changes to professional development

One of the aims of RPR is to improve the way doctors engage with professional development activities and planning. Post-RPR, 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 adjust their PDPs to target opportunities for development. Approximately half of the doctors who responded to the survey post-RPR had already made changes to their PDPs as a result of their participation in RPR.

Looking back twelve months later, smaller proportions of doctors reported actual changes to the PDP, suggesting that some who had intended to do so were not able to or chose not to follow through.

Factors with the potential to influence the effectiveness of RPR

Doctors' understanding of the RPR and specifically their expectations of benefit could be improved. Findings suggest that for a minority, the RPR is stressful, perceived as an audit and as generating an incomplete view of their practice.

Additional communication, particularly with the reviewer in advance of the practice visit and after the report, may help to improve both the perception and experience of RPR.

Adapting the RPR process to atypical practice contexts (locum, travel doctor, patients who are in mandatory treatment) is a challenge for the programme, especially as the scope expands. Even in more traditional contexts it captures and assesses a snapshot of information. Continuing to embed RPR in the wider context of

professional practice and continuous improvement may help reduce stress and improve RPR usefulness for some doctors. Reports that are found to be useful are linked to more changes in practice resulting from the programme.

The reviewers

The reviewers have a key role in the RPR process. Results from the new survey of reviewers are consistent with those from the 2014 survey.

Most doctors felt that their reviewer demonstrated appropriate skills to evaluate their practice, consistent with results from the previous reports. A perceived mis-match between the reviewed doctor's practice and the reviewer was a reason for dissatisfaction for some doctors. Doctors in atypical practices more commonly comments about this.

Almost all reviewers felt they had the necessary training, support and information about the doctor to be effective reviewers.

More than half felt they were completing the right number of reviews, with just under one-third wanting more reviews and a very small proportion wanting fewer. About one per month was the most common ideal number of reviews.

Reviewers were confident their feedback led to changes in practice that would improve care for patients. However, they were uncertain whether those changes took place because they did not have any follow-up contact with doctors.

Giving feedback is a skilled role. Developing the reviewers' ability to provide feedback on opportunities to develop the reviewed doctor's practice could 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 that they are effective as reviewers even when the doctor being reviewed has a different scope of practice to their own
- How to provide feedback and advice that would assist RPR doctors to use information from the review to make changes.

Overview

- **Evidence based:** The RPR design is based on evidence. The literature summary provided in previous reports highlighted evidence that audit and feedback can improve practice and patient outcomes.
- **Doctors are reporting making changes:** 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.

- **Change 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 data available is still limited. This area of the evaluation will continue to be developed as more doctors complete RPR.

- **The reviewers:** The reviewers play a crucial role in the RPR process. As in the 2014 survey, reviewers were positive about RPR and its effect on the reviewed doctors.

- **Strengthening the programme:** Surveys and interviews suggested some aspects of the programme where there is potential for improvement:
  - Continuing to promote the purpose of the review to reviewed doctors and the sector as a whole.
  - Reassuring doctors about flexibility in the process to accommodate atypical practice.
  - Building on follow-up with the doctors after the review to support practice changes and see the result of their work.

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. Additional completions will facilitate time-series analysis.

Analysis of bpac^{nz} data on professional development plans will be incorporated into the next report, which will be provided in mid-2016.

1. Background to Regular Practice Review (RPR)

1.1 Establishment of RPR

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

Continuing professional development programmes (CPD) are one of the mechanisms professional organisations use to ensure the competencies of their members are maintained. 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. RPR involves:

- Pre-visit: Review of the doctor's professional development ePortfolio, prescribing and laboratory test reports, 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.

To date, 439 doctors have taken part in a regular practice review.

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

2. 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}.

2.1 The evaluation design

The RPR evaluation 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 survey questionnaires and interview guides.

2.2 Information sources

Like previous reports, this report updates information drawn from interviews and surveys of doctors participating in RPR[2]. Data have been collected from online surveys sent to all participants at two-weeks following the doctor's participation in RPR. Doctors completing the survey are asked if they are available to be interviewed. In interviews doctors are asked for the name of their collegial relationship provider.

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

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

Figure 1 provides a summary of the data sources used for the evaluation of RPR to date.

Data from:	Doctors	Reviewers
Online surveys	• Post-RPR survey of participating doctors (194 of 301, 65%) • Twelve-months after RPR (36 of 60, 60%)	• 2014 survey of reviewers about their role (19 of 19, 100%) • 2016 survey of reviewers about their role (22 of 33, 67%)
Interviews	• Post-RPR interviews with participating doctors (39) • Interviews with doctors approximately 12 months after RPR (6)	• 2014 interviews with reviewers about their role (6) • 2016 interviews with reviewers about their role for RPR (9)
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Other	• A review of the literature about professional development	
	• Interviews with collegial relationship providers (7)	

Figure 1. Information sources for the evaluation to date.

2.3 Strengths and limitations at this stage of the evaluation

The evaluation findings are based on the reviewed doctors' self-reported changes. Objective information about the extent changes have been made are limited until it is possible to compare changes in rating between the first and second time doctors participate in RPR.

The evaluation is based on surveys and interviews. The response rate from participating doctors was very good. Comparison with demographic data from bpac^{nz} about the whole cohort shows 65% of doctors participating in RPR since the evaluation began have completed the post-RPR survey.

There were some differences in the demographic profile of doctors who completed just the post-RPR survey and those who completed both the post-RPR survey and the twelve-month survey. For clarity, comparisons between the post-RPR survey and twelve-month survey responses are based on only doctors who answered both surveys.

3. The participating doctors

Doctors completing the online surveys were fairly evenly divided between those with fewer than ten 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. Most of the doctors who had been in practice in New Zealand for fewer than ten years were overseas trained (Table 1).

Around two-thirds 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-quarter of the post-RPR survey doctors.

There were small differences in the profiles of the doctors completing the post-RPR and twelve-month survey. Notably, a higher proportion of doctors had been practicing in New Zealand for 11 to 30 years.

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

Characteristic	Post-RPR survey (n = 194)	Twelve-month survey (n = 36)
Practicing in New Zealand for:		
• Less than 10 years	46%	36%
• 11-30 years	42%	56%
• 30+ years	12%	8%
Training location:		
• New Zealand	36%	31%
• UK	25%	28%
• South Africa	10%	17%
• Other	21%	17%
• Unknown	9%	8%
English not first language	23%	22%
Current role:		
• GP	66%	75%
• Other[3]	34%	25%

[3] Roles included obstetrics and gynaecology, medical officers, certifying consultants for abortion, primary youth health doctor, skin cancer physician, family planning clinicians, emergency department doctors and psychiatrists.

4. Changes following participation in RPR

Summary

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

Changes to practice

Overall, nearly half (48%) 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. Around half of the post-RPR survey respondents agreed that participating in RPR had improved the care they deliver to their patients and improved their practice in other ways.

Most doctors continued to report changes in practice at twelve-months. Smaller but still substantial proportions thought RPR had helped improve the care they delivered to their patients (33%) and/or had improved their practice in other ways (39%).

Doctors who learned new development opportunities were more likely to have made changes to their practice.

Changes to professional development

One of the aims of RPR is to improve the way doctors engage with professional development activities and planning.

Post-RPR, 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 adjust their PDPs to target opportunities for development. Approximately half (51%) of the doctors who responded to the survey had already made changes to their PDPs as a result of their participation in RPR. Looking back twelve months later, smaller proportions of doctors reported actual changes.

This section examines the differences participating in RPR has made for doctors post RPR and the extent changes have been sustained twelve-months later[4].

[4] Post-RPR results are reported for all doctors who participated in the evaluation. Twelve-month survey results are reported for doctors who completed both the post-RPR and twelve-month surveys.

4.1 Changes in practice

4.1.1. 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 (48%) 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 2).

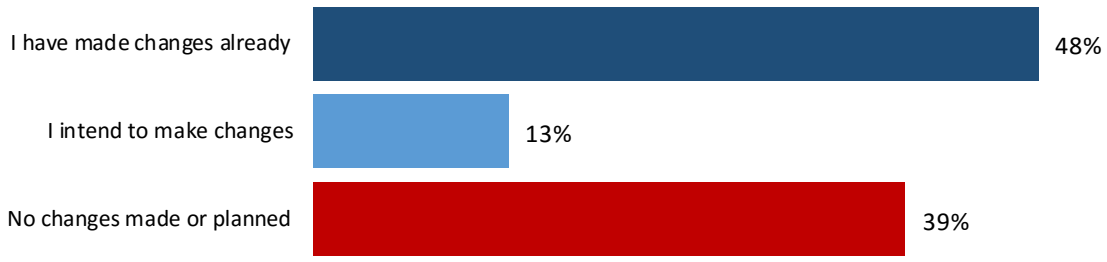

Figure 2. Proportion of survey respondents who had made changes already, who intended to make changes (but had not already done so) and who did not intend to make changes (n = 194).

Around half of the post-RPR survey respondents agreed that participating in RPR had improved the care they deliver to their patients and improved their practice in other ways (Figure 3), consistent with previously reported results.

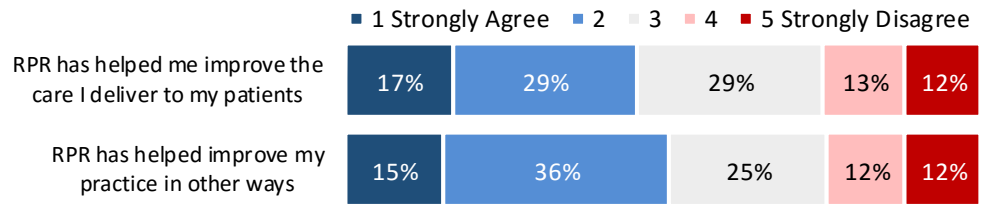

Figure 3. Survey respondents' views on the impact RPR has had on their practice (n = 194).

The proportion of doctors who reported changes in practice as a result of RPR increased until the first half of 2015, then dropped slightly (Figure 4). These results may indicate improvement over time.

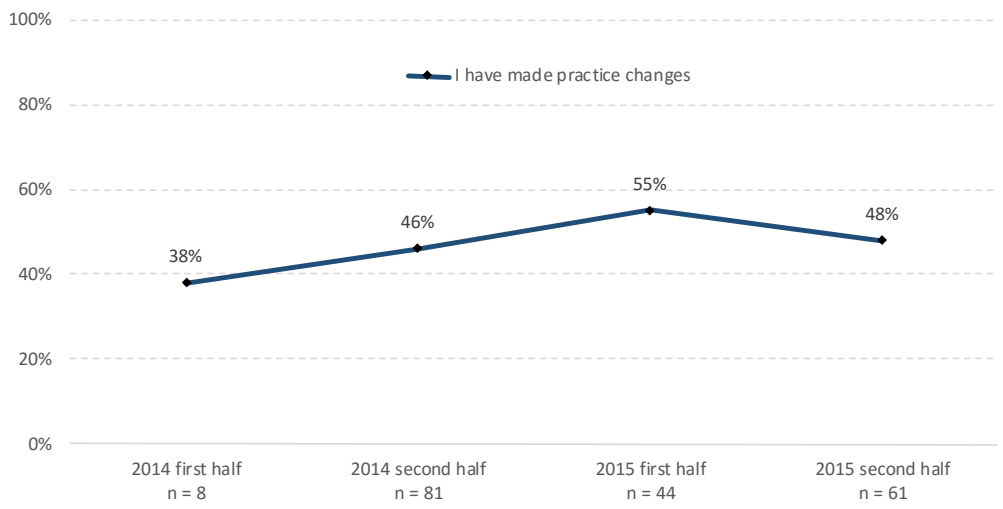

Figure 4. Proportion of post-RPR survey respondents who had made changes to practice by year-half.

4.1.2. 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 October 2015 report.

Table 2 below presents the differences in proportions between the groups of doctors in the survey, with statistically significant differences among groups of doctors (e.g., English as a first language versus English as a second language) highlighted in bold. The addition of new responses in the last three months has made differences in training location and role significant. As more responses are collected, more differences may emerge or become significant.

Table 2. Proportion of respondents with certain characteristics who had already made changes at the time of the post-RPR survey (n = 194). Statistically significant differences are bolded (p < 0.05).

	Number of doctors	Have made changes to their PDP	Have made changes to their practice	Would recommend RPR to their colleagues
English as a first language	150	**69 (46%)**	**64 (43%)**	84 (56%)
English as a second language	44	**29 (66%)**	**29 (66%)**	30 (68%)
Less than 10 years in practice in NZ	89	48 (54%)	47 (53%)	55 (62%)
11-30 years in practice in NZ	82	38 (46%)	35 (43%)	43 (52%)
30+ years in practice in NZ	23	12 (52%)	11 (48%)	16 (70%)
Current role as a GP	126	**73 (58%)**	67 (53%)	73 (58%)
Other current role	68	**25 (37%)**	26 (38%)	41 (60%)
Learned no new development opportunities in their report	88	**29 (33%)**	**22 (25%)**	**33 (38%)**
Learned new opportunities for development in their report	106	**69 (65%)**	**71 (67%)**	**81 (76%)**
Trained in NZ	70	32 (46%)	29 (41%)	**34 (49%)**
Trained elsewhere	124	66 (53%)	64 (52%)	**80 (65%)**

4.1.3. Twelve months later: changes to practice

Most doctors continued to report changes in practice at twelve-months.

Agreement that RPR had led to changes in practice differed slightly between the post-RPR survey and the twelve-month survey (53% compared to 47%). The change in scores (from a paired samples t-test converting answers to a 1-5 numeric scale) was not significant ($t(35) = 0.63$, $p = 0.54$).

Smaller but still substantial proportions thought RPR had helped improve the care they delivered to their patients (33%) and/or had improved their practice in other ways (39%) (Figure 5). Both of these proportions decreased between the post-RPR survey and the twelve-month survey, from 53% and 58% respectively. Most of the changes were doctors moving to a more neutral stance, rather than disagreeing.

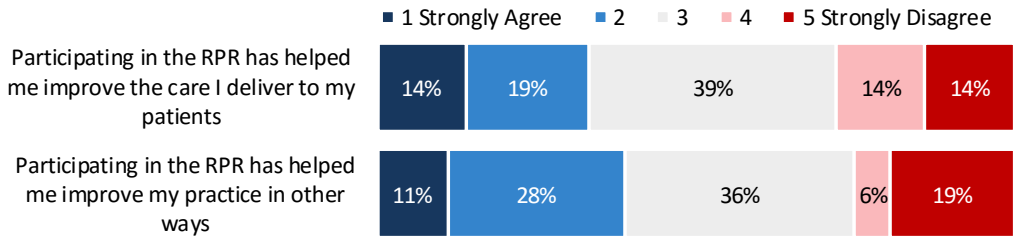

Figure 5. Proportion of twelve-month survey respondents (n = 36) who agreed with statements about making changes to their practice.

All of these doctors who reported changes at twelve-months were positive about RPR and would recommend it to their colleagues.

4.1.4. At twelve-months: 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, only one variable (whether nor not doctors learned new development opportunities in their RPR report) has a significant effect (Table 3). Only the highlighted differences are statistically significant. As more doctors complete the twelve-month survey, we expect more differences to reach statistical significance.

Table 3. Characteristics doctors reporting outcomes in the twelve-month survey (n = 36). Significant differences are bolded (p < 0.05).

	Number of doctors	Have made changes to their PDP	Have made changes to their practice	Would recommend RPR to their colleagues
English as a first language	28	18 (64%)	12 (43%)	14 (50%)
English as a second language	8	7 (88%)	7 (88%)	7 (88%)
Less than 10 years in practice in NZ	13	8 (62%)	4 (31%)	8 (62%)
11-30 years in practice in NZ	20	15 (75%)	14 (70%)	12 (60%)
30+ years in practice in NZ	3	2 (67%)	1 (33%)	1 (33%)
Current role as a GP	27	17 (63%)	14 (52%)	15 (56%)
Other current role	9	8 (89%)	5 (56%)	6 (67%)
Learned no new development opportunities in their report	17	8 (47%)	**5 (29%)**	**6 (35%)**
Learned new opportunities for development in their report	19	17 (89%)	**14 (74%)**	**15 (79%)**
Trained in NZ	11	9 (82%)	5 (45%)	7 (64%)
Trained elsewhere	25	16 (64%)	14 (56%)	14 (56%)

4.1.5. Examples of the changes doctors said they had made

Examples of changes included improvements in consultation style and interaction with patients, improvements to note taking, habits in prescribing and ordering tests, and better use of resources. Improvements in note taking and recording were the most commonly mentioned. The types of changes doctors reported have remained consistent over time.

Some comments from participating doctors are provided in Table 4. Examples were provided by doctors who were negative about the RPR process as well as those who had positive views.

Table 4. Doctors' descriptions of changes they have made as a result of participating in RPR. Comments mentioned more often are listed higher in the table.

Area of change	Examples of changes
Improved notes and record keeping	*I write my notes after seeing each patient now. I try to abbreviate more. I am trying to be more mindful about what I can achieve in 15minutes and ask people to return for follow up more.* *Ensuring appropriate documentation of clinical notes. Going deeper into patient history beyond presenting complaint.* *Reviewed notes of applicable patients and recalled for consideration.*
Changed how consult is managed	*I write my notes after seeing each patient. I try to abbreviate more. I am trying to be more mindful about what I can achieve in 15minutes and ask people to return for follow up more.* *Tried to change consultation style, trying to prioritise patient questions.*
Review PDP and CME	*Changing some of the PDPs to be more realistic and achievable. Reviewing the PDPs on regular basis. Being more specific in my CME log.*
Reviewed prescribing	*Adapted prescribing to the guidelines where possible and when appropriate.* *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.*
Communicating more effectively	*Changed how I word questions to patients. Better use of silence.* *Incorporation of more patient information resources.* *Communicating more effectively with patients who present with lists to ensure priority of needs addressed in 15 minute consultations.*
Reviewed tests ordered	*I am a bit more critical about which lab tests I order.* *I have changed my way of approaching thyroid function testing.*
Aspects of patient care	*I wash my hands regularly.*

	One of the tips was a suggestion to take data set (pulse, BP, temp) on all patients- it only takes a few seconds and I have found it a good habit. *Improved note making, increased consideration of antibiotic prescription, increased awareness of hygiene.*
E-management	*I've made a lot more use of our IT, the IT person helped.* *I put extra things at the bottom of my screen.*
Self-audit	*Planning my next audit.* *Starting to audit my clinic record and make a protocol to avoid the chance of missing document.*
Self-care	*I am trying to take more time off, as this was the only recommended change.* *Changes have only been self-care changes - I have created more balance between work and home life.*
Cultural competency	*Taking specific interest in Māori and Pacific cultural aspects and trying to integrate them in consultations.*

4.2 Changes to professional development

One of the aims of RPR is to improve the way doctors engage with professional development activities and planning.

4.2.1. Post-RPR changes to professional development

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 adjust their PDPs to target opportunities for development (Figure 6).

There is the potential to compare actual changes to PDPs based on administrative data, however there are challenges in identifying the effect of RPR.

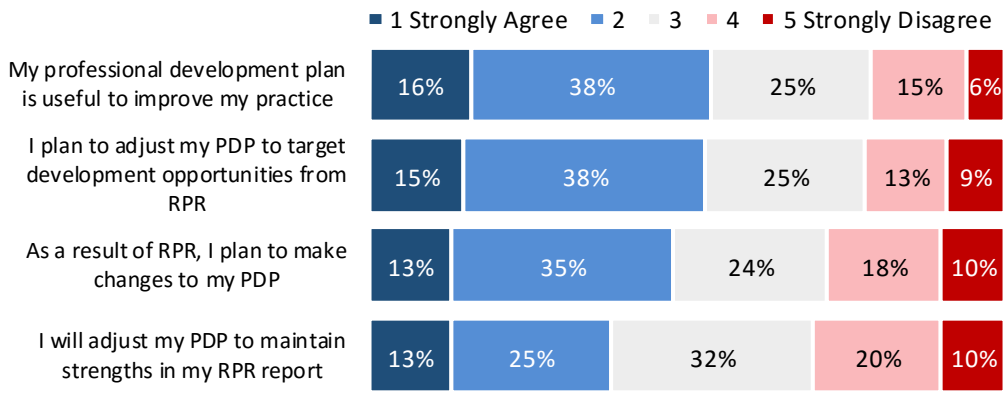

Figure 6. Doctors' views on their professional development plans (n = 194).

Post-RPR, 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 7). This proportion has remained consistent with results recorded in October 2015.

Figure 7. 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, a result that has remained consistent with previous reports.

Of the two-thirds of doctors who completed the post-RPR survey who did not discuss professional development with their RPR reviewer, some reported discussing administrative details such as 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.

Overall, half (55%) of the responding doctors agreed or strongly agreed RPR identified new opportunities to develop their practice. Of those doctors:

- Two-thirds (65%) had made changes to their PDPs (compared to 33% of other doctors)
- Most (81%) planned to adjust their PDPs to target the development opportunities identified in their RPR report (compared to 18% of other doctors).

A small proportion (5%) of the responding doctors said that their RPR reports identified new opportunities for development but they did not plan to adjust their PDPs to target those areas. These doctors did not comment on their professional development plans specifically, but did comment on the process as a whole. They

generally objected to being asked to participate in a review or the process of the review. For example, one said:

> *I don't like them. It infringes on a doctor's doctor- patient relationship. All New Zealand trained doctors have to do such tests/ training before embarking on their career so repeating it seems unnecessary. Why reinvent the wheel so to speak …*

The proportion of doctors who had made changes to their professional development plans was highest in the second half of 2014 and has been lower in each half-year since (Figure 8).

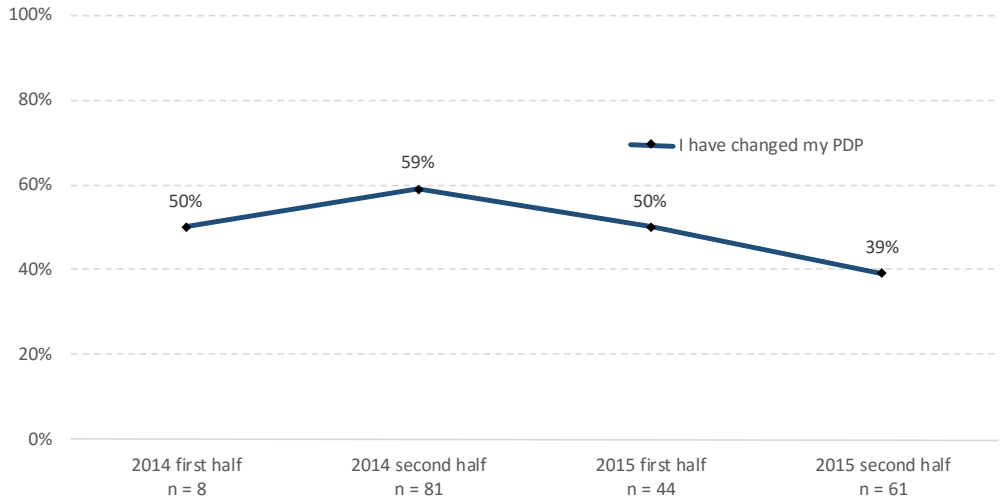

Figure 8. Proportion of post-RPR survey respondents who had made changes to their PDPs.

4.2.2. Use of e-portfolios

As in earlier reports, doctors gave mixed feedback on their use of their e-portfolios. A little over half agreed that they updated their e-portfolio at regular intervals (57%) and that their e-portfolios were useful tools to improve practice (52%) (Figure 9).

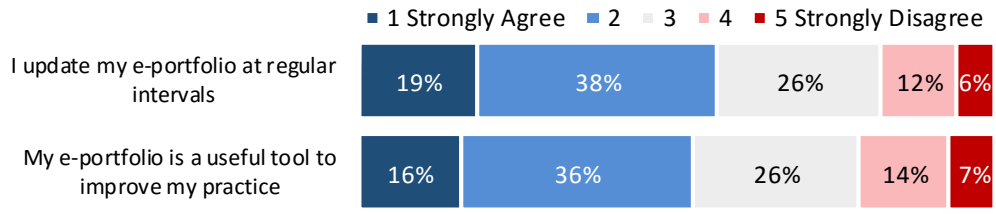

Figure 9. Doctors' views on their e-portfolios (n = 194).

4.2.3. Twelve months later: changes to professional development

In the post-RPR survey, a relatively high proportion of the twelve-month cohort of doctors said they planned to make changes to their PDP as a result of their participation in RPR. Looking back twelve months later, smaller proportions of doctors reported actual changes (Figure 10).

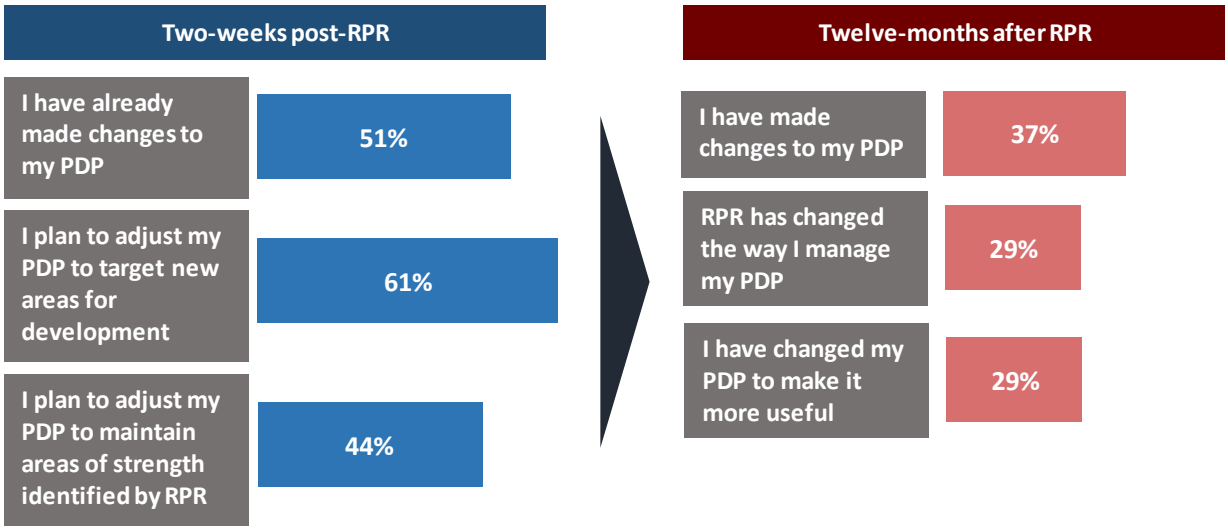

Figure 10. Comparing the views of the twelve-month survey cohort on changes to professional development plans post-RPR and after twelve months (n = 36).

4.2.4. Examples of changes to professional development

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

- Fine tuning their PDP

More study and build up experience on paediatric infectious disease.

- Participating in network meetings

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].

- Attending training to improve cultural competence
- Entering vocational training
- Improving their management of their professional development.

I've changed the way I document my CME in the bpac^{nz} system; PDP is set first, then followed by the appropriate ongoing education.

I have tried to broaden the range of topics studied in CME. I have chosen my clinical audit to be more relevant to my aim for this year.

- 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 "utilization of laboratory tests in 2015".

5. Factors with the potential to influence the effectiveness of RPR

Understanding the purpose of RPR: Before their RPR visits, one-third (32%) expected the RPR to be useful but nearly as many (28%) thought it would not be useful. Misunderstanding the purpose of RPR is still relatively common, leading to anxiety and reducing the value of RPR for the participating doctor. As RPR becomes more embedded in professional development in the sector, this negative reaction to RPR may lessen.

Logistics: It is important that the RPR process and the reviewers are flexible and manage the differences among practices. Generally, doctors were positive about how the reviewers managed differences in practices during site visits but before the visit some were worried about aspects of the process. Opportunities to discuss their concerns beforehand help alleviate their anxiety and allowed them to plan for the practice visit.

Tools and components: Of all the component, the practice visit was the main source of potential stress for some doctors. A majority of doctors reported the practice visit to be positive (72%) and the report to be useful (66%). About half of doctors who used the patient (51%) and multi-source feedback (54%) tools thought they were useful.

Overall experience with the RPR: Following the RPR, a majority (58%) reported that they would recommend RPR to their colleagues shortly after completing the review. However, this enthusiasm lessens after 12 months, with 44% of doctors reporting the RPR to be useful, and 44% reporting that they would recommend it.

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. There may be opportunity to add further follow-up, particularly where doctors had more areas for development identified by RPR.

5.1 Understanding the purpose of the 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've heard about it from two other colleagues that have been through it so they described it to me and they described it as meeting with older or experienced GP. So they had had their RPR and I think they both found them useful.

Doctors are provided with information about RPR in the lead up to the reviewer visiting their practice. However, even some of the interviewed doctors who had heard about RPR or discussed it with colleagues before they were invited to participate misunderstood its purpose. Many 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 three issues:

- **Inequity:** They should not have to participate in this process when other doctors did not have to.

  I felt that the majority of us are being punished for the sins of the minority.

  I guess my objection is just because they've had some postgrad training it doesn't mean they are better at their job. Sometimes it makes a difference and sometimes it doesn't. I know that because all I've been doing is locum work and many of the doctors are vocationally registered, and some of them are good and some of them aren't. The council doesn't seem to get that.

- **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:

  Can't think of a way to make it less stressful having someone sit in the room with you!!

- **Unnecessary:** Believing that an RPR should only be for underperforming doctors. For example, one said:

  As I said, I felt this was a complete waste of my time.… I believe the same thing could have been done in less than an hour. Perhaps sit in with three patients and do a random notes review. You will see that I seemed to have passed the RPR with flying colours but note that I've been a GP for 17 years and have maintained good (I hope) clinical practice without the RPR rubbish.

The risk is that doctors who see RPR as a pass/fail audit 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 had a powerful negative effect on feedback for postgraduate general practice medical trainees.

I have personally spent my entire 31 years as a GP attending seminars/ launches/ peer reviews/ skills updates / reading journals at my bedside and engaging in active debates and discussions and all other sorts to keep abreast of an ever changing and ever challenging environment.… An observation by a Fellow creates nerves/ anxiety and can

make the entire 4-8 hours go pear shaped on that one particular day of observation, and this can result in poor reflection in a report that can be humiliating.

Increasing understanding of RPR as a quality improvement programme could increase satisfaction amongst the few doctors who were not positive about RPR after their reviews. The purpose of RPR may become better and more widely understood as it becomes more embedded. However, there has not yet been an increase in the proportion of responding doctors who report they thought RPR would be useful before their practice visit (Figure 11).

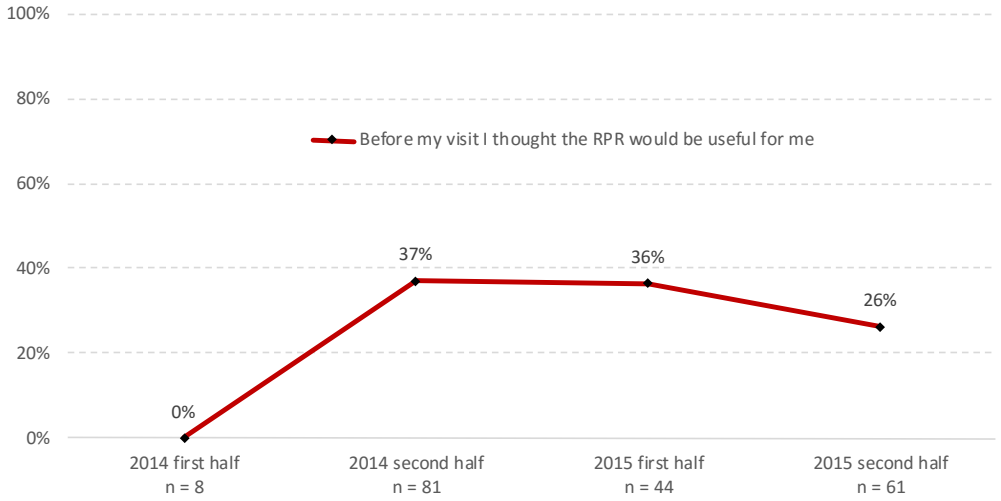

Figure 11. Proportion of post-RPR survey respondents who agreed or strongly agreed that they thought RPR would be useful for them before their practice visit.

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.

Expectations of the RPR process reflect this mix in understanding and concerns. Those who anticipated the visit would be useful welcomed the opportunity to discuss and receive feedback on their practice. However not all doctors thought that the RPR would be a useful experience. Overall, one-third of doctors who completed the RPR-post survey thought that RPR would be useful or very useful before they took part, whereas a similar number (28%) thought it would not be useful (Figure 12).

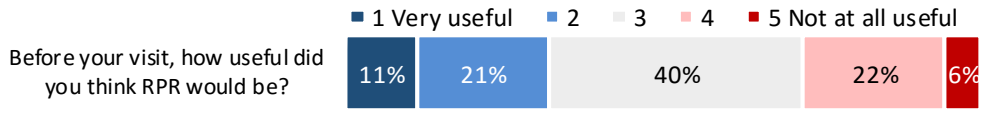

Figure 12. Views of doctors who completed the post-RPR survey on how useful they thought RPR would be before their practice visit (n = 194).

Figure 13 provides a range of comments from doctors who thought the visit would be useful to those that did not.

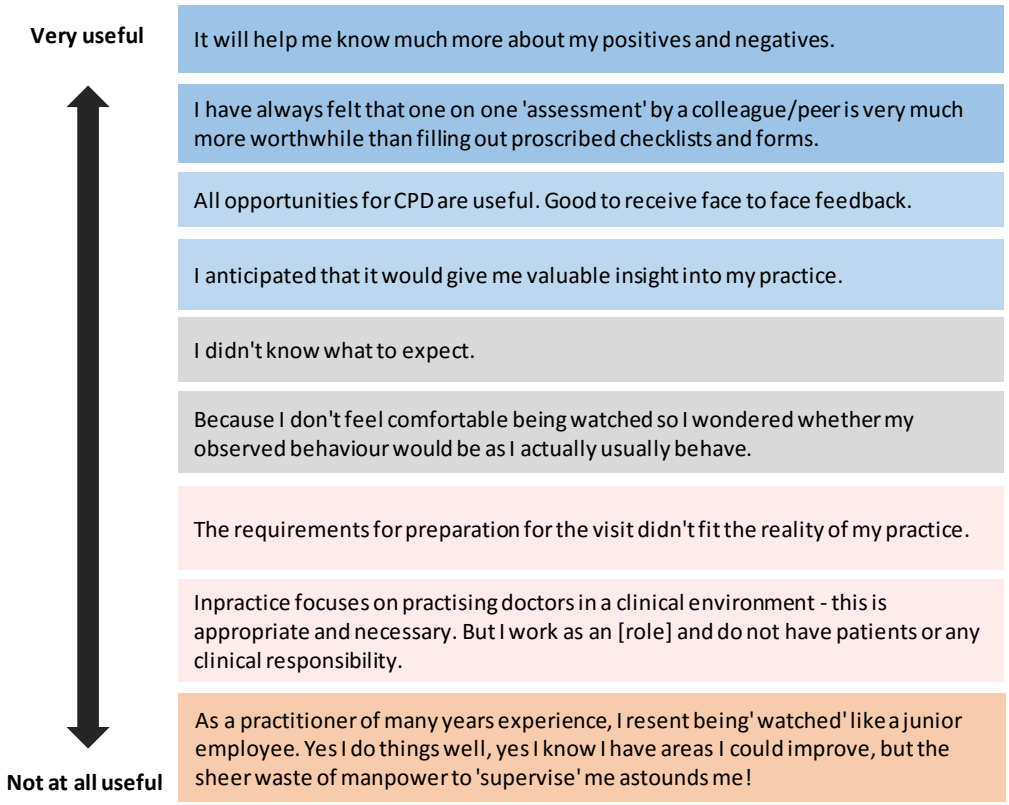

Figure 13. Examples of doctors' reasons for believing RPR would be useful or not useful before their participation.

5.2 Visit preparation and logistics

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[5]
- Arrange the practical aspects of the practice visit, including making appointments with patients and obtaining their consent for the reviewer to observe the appointments.

[5] These feedback tools are administered by Bpac[nz]. Doctors are asked to distribute feedback forms to colleagues and/or patients in advance of their RPR practice visit.

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

> *It was pretty straight forward for what to do.*
>
> *There wasn't any problems organising times or days, the gentleman (reviewer) and I were busy people but we figured it out, it was as straightforward as it could be. I would say it was very straight forward dealing with him directly.*

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 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 and manage these differences. In most cases, the reviewers handled these situations well on the day. One doctor 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 in the preparation stages before the visit to discuss why their practice was different so that they could be confident the visit would run smoothly. If doctors 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.

5.3 Overall impressions

In the post-RPR survey, a majority (58%) of doctors agreed that they would positively recommend RPR to their colleagues (Figure 14). However, doctors who completed both surveys were less likely to recommend RPR twelve months later than in the post-RPR survey.

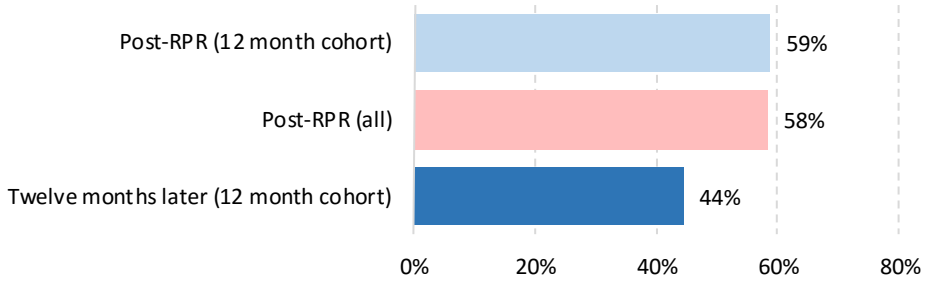

Figure 14. Post-RPR (n = 194) and twelve-month cohort's (n = 36) agreement that they would positively recommend RPR to their colleagues.

The seven doctors who changed their mind about positively recommending RPR to their colleagues between the post-RPR survey and the twelve-month survey made negative comments about:

- The cost of *Inpractice*
- The time cost of RPR and particularly the practice visit
- Wanting more review of their practical skills.

For the twelve-month cohort, the same proportion (44%) thought RPR was useful or very useful in retrospect. (Figure 15).

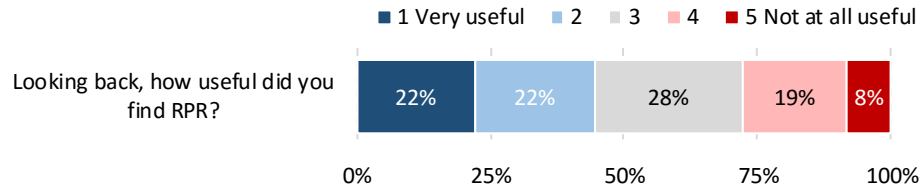

Figure 15. Views of doctors in the twelve-month cohort (n = 36) on the usefulness of RPR in hindsight.

5.4 RPR tools and components

Overall, a majority of doctors reported the practice visit to be positive and the report to be useful. About half of doctors who used the patient and multi-source feedback tools thought they were useful. The practice visit is the most significant part of RPR and doctors' experience of the visit was an important factor in their views on RPR as a whole.

5.4.1. Practice visits

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 with only a small proportion disagreeing that the practice visit was a positive experience (Figure 16). Results remain consistent with those from earlier reports.

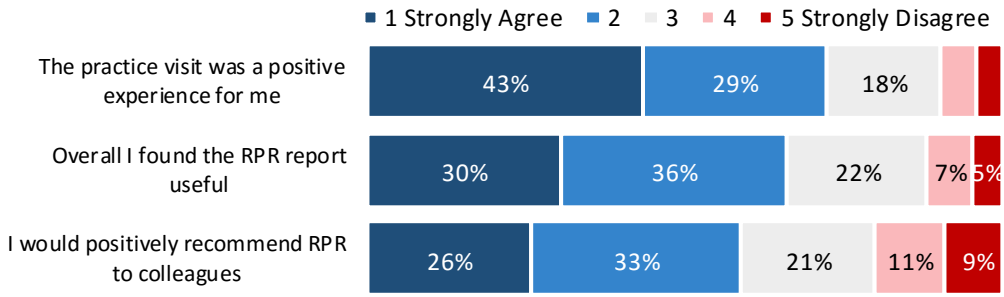

Figure 16. Survey respondents' views on their experience of the RPR practice visit (n = 194).

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.

It was a good opportunity to demonstrate to another doctor the role I do.

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 (Figure 17).

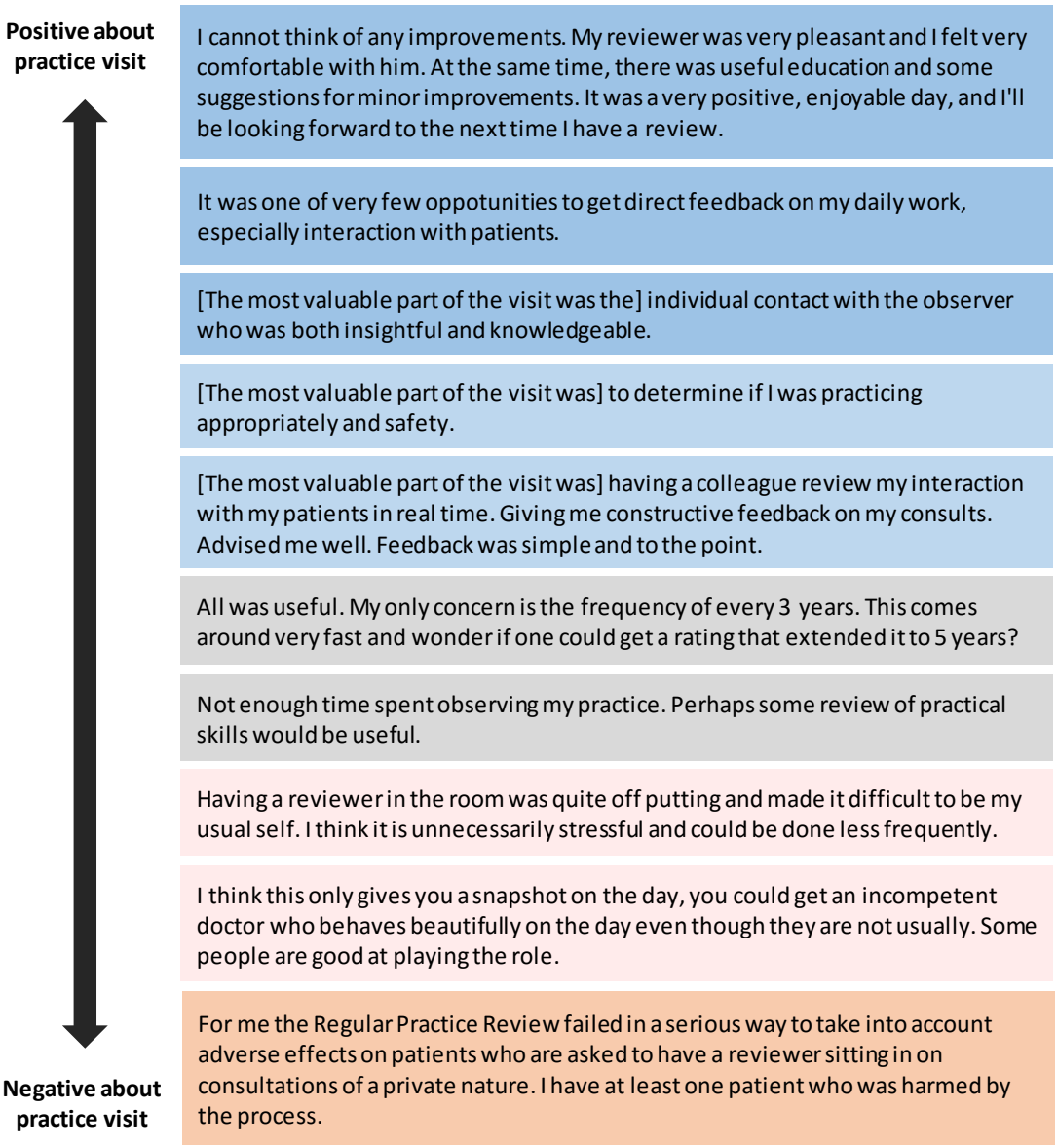

Figure 17. A selection of doctors' comments about the practice visit.

In some cases doctors raised concerns about the effect of the practice visit on their patients. The issues were around obtaining consent from the patient for the reviewer to observe an appointment, and having the reviewer observe an appointment, potentially posing a risk to patients' wellbeing. One doctor 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 patients.

Analysis of post-RPR survey responses does not yet provide any evidence for improvement in the perception of the RPR report or practice visit over time (Figure 18).

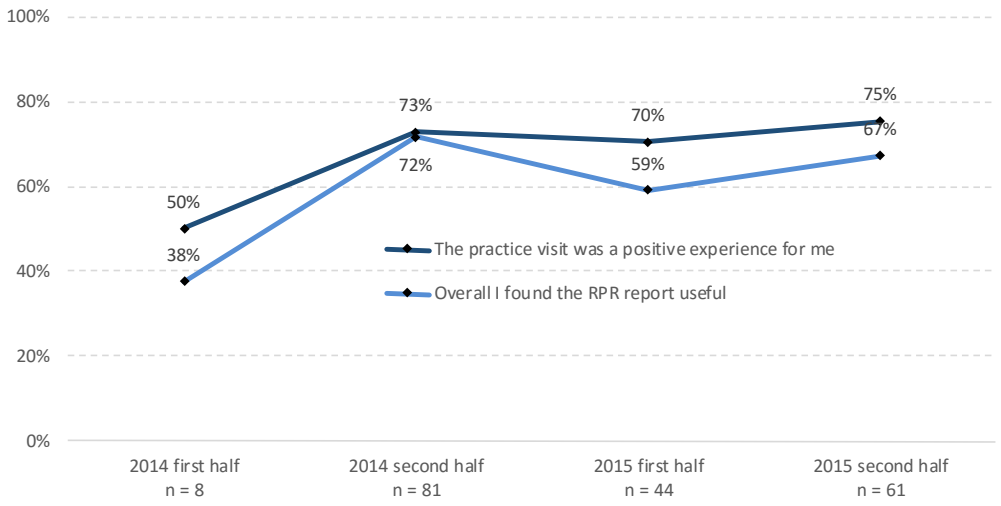

Figure 18. Proportion of post-survey respondents who agreed or strongly agreed that the practice visit was a positive experience and that they found the RPR report useful.

5.4.2. Other feedback tools

More than half (60%) of the doctors who completed the post-RPR survey had completed the patient feedback form, consistent with results from October 2015. Overall, of those using the tools, about half agreed that they provided useful information (Figure 19).

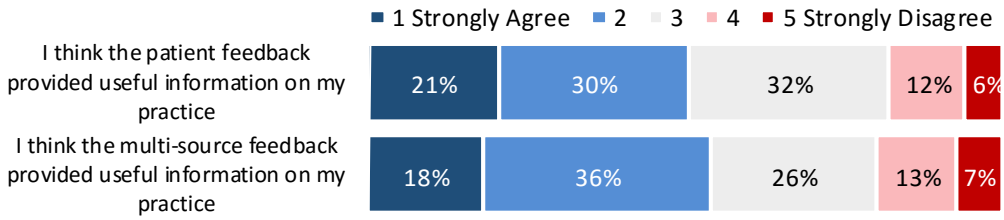

Figure 19. Survey respondents' views on whether the patient (n = 117) and multi-source feedback (n = 165) tools provided useful information about their practice (N/A responses removed).

Some of the doctors who reported that the patient and/or multi-source feedback tools were not useful may have had difficulty completing them. Thirty-three doctors strongly disagreed or disagreed that the multi-source feedback was useful and were more negative about RPR in general.

Comments from doctors who had difficulty with the feedback tools focused on:

- Not understanding what they were required to do.
- The questions being unsuitable for atypical practices, 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.

- A doctor providing a mandatory treatment that patients did not necessarily want. After explaining the situation to bpac[nz] this doctor was not required to collect patient feedback.

  It was quite difficult because of my patients … the majority of them don't want to be treated and so it's a bit different.

- Not having established patient relationships. This was most often an issue for doctors working in locum positions (18 of the 194 doctors who completed the post-RPR survey).
- New to practicing in New Zealand and not having much contact with other health professionals in their role beyond referral letters.

Analysis of the patient feedback form data from bpac[nz] showed that an average of 35 patient feedback forms were completed for each of the 227 doctors who used the patient feedback tool. The overwhelming majority of ratings were positive with almost all of the doctors having an average rating from their patients of between 'good' and 'very good' in all of the patient feedback categories.

Less than half (41%) of doctors received one or more negative ratings in areas covered by the patient feedback tool. Note that for many, this was a single negative rating from one of an average of 35 patients per doctor. Areas that most commonly had at least one negative rating for the 227 doctors were:

- Confidentiality (59)
- Honesty and trustworthiness (47)
- Explanations about conditions and treatments (26)
- Making the patient feel at ease (24)
- Assessing the patient's medical condition (22)
- Involving the patient in decisions about their treatment (20)
- Listening to the patient (19)
- Involving the patient's family/Whanau in the case (17)
- Providing or arranging treatment for the patient (15)
- Being polite (14 doctors).

5.5 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 20).

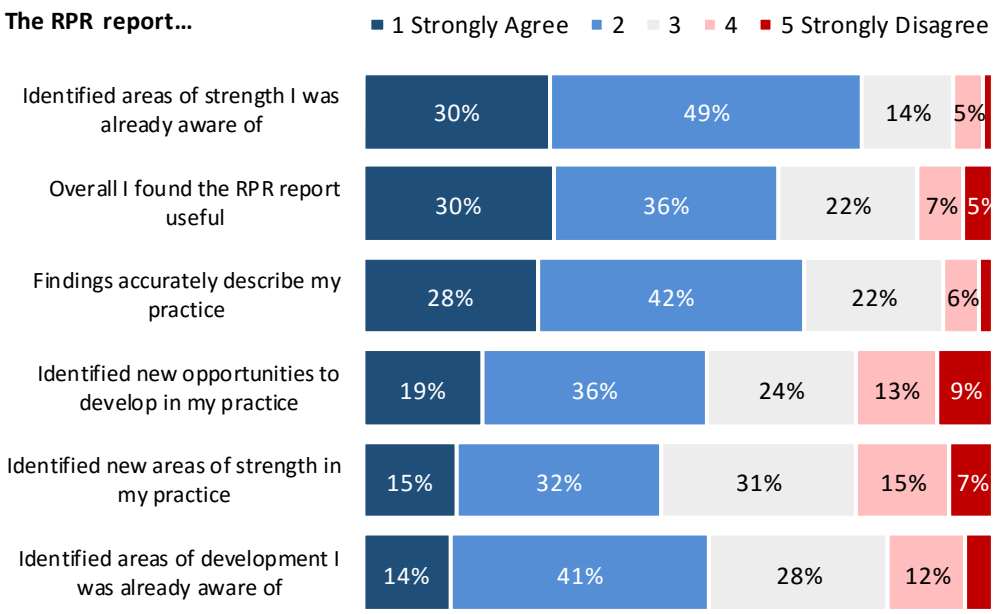

Figure 20. Survey respondents' views on their RPR reports (n = 194).

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. Unsatisfactory ratings were given for:

- Appropriate standard of care (3%)
- Notes facilitate continuity of care (2%)
- Record is clear, accurate, contains the required information (2%)
- Clinical practice examination (1%)
- Ability to use the PMS (1%).

More than half of the reviewed doctors received superior ratings for each of the review areas (Figure 21). Almost all of the others achieved satisfactory ratings.

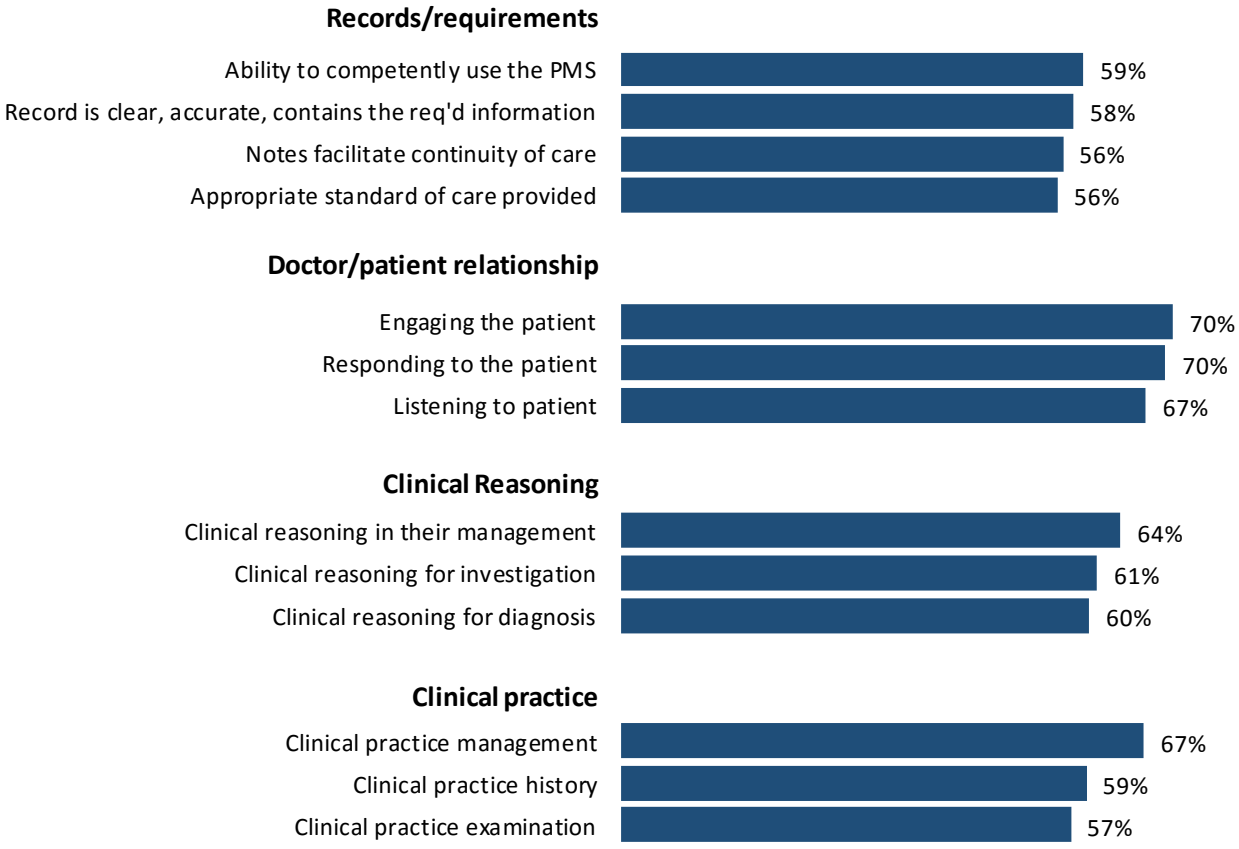

Figure 21. Proportion of doctors receiving the 'superior' rating for each of the RPR report rating questions (n = 380-402).

Encouraging doctors' development requires that they are 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 (55%) of the responding doctors said that RPR identified new opportunities to develop their practice.

> *To some extent she was pointing out things that I maybe hadn't thought of, so she outlined somethings I was aware of and others that I wasn't so much.*

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 22.

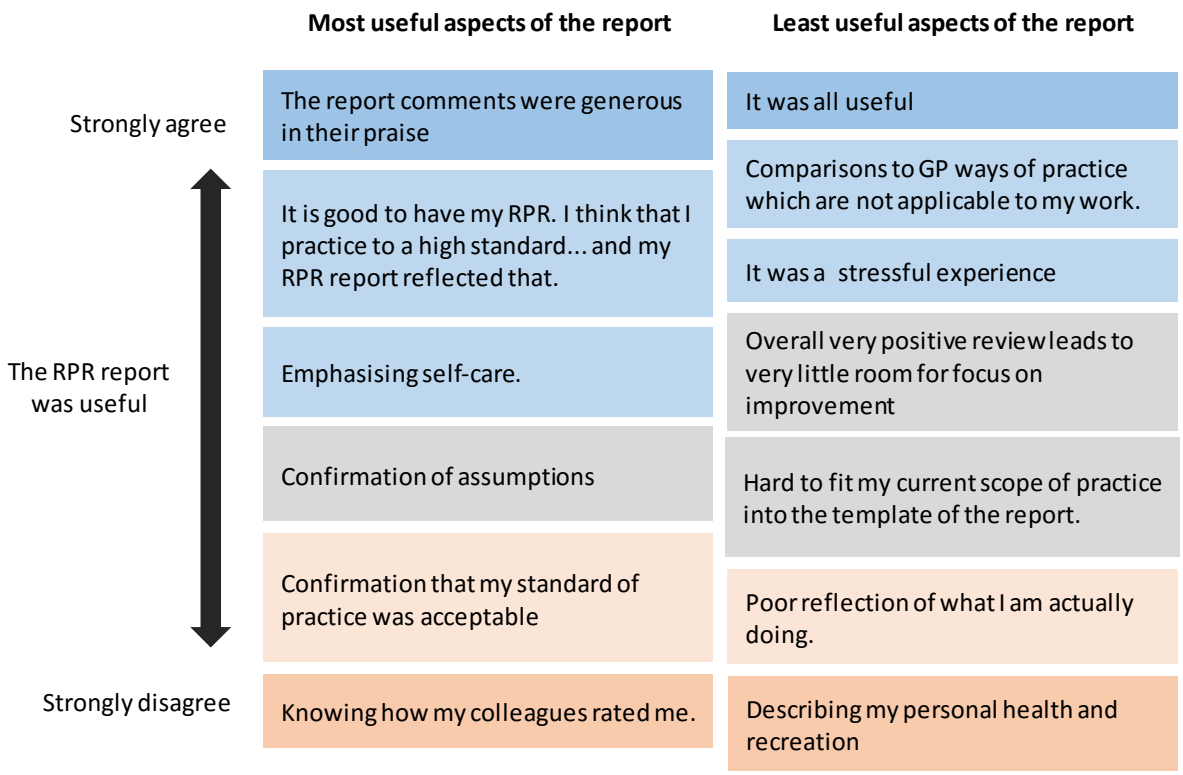

Figure 22. Examples of doctors' comments in the post-RPR survey on the most and least useful aspects of the RPR report.

5.6 Follow-up after the review

As noted above, half (55%) of the responding doctors said that RPR identified new opportunities to develop their practice. Almost all (86%) 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.

CRPs give the doctors feedback on a more regular basis than RPR occurs. As noted earlier, the reviewed doctors most commonly discussed their professional development plans with their 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.

In addition, some reviewers wanted an opportunity to contact the doctors again or view their PDP e-portfolio 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.

5.6.1. 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. Those who had answered the twelve-month survey were more likely to have discussed it with other colleagues than those who had just completed the post-RPR survey (Table 5).

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-months later (n = 36)
Collegial relationship provider	66%	58%
Other colleagues	38%	50%
RPR reviewer	34%	8%
Employer/manager	16%	22%
Inpractice medical advisor	-	3%
Other	13%	-

In the twelve-month survey, doctors commented on the changes they made to their professional development plans as a result of discussion with people in the different roles. Changes in their PDPs due to RPR focused on increased understanding of the idea and implementation of PDPs, while the changes from speaking with others after the RPR were more related to making practical changes.

Discussions with collegial relationship providers

Doctors have described making their PDPs more focused and specific as a result of discussion with their CRPs. Examples include more focus on: GP specific skills, skills in area of interest, use of patient management system, patient notes and more focus on retirement/ succession needs.

I decided to spend time developing skills in those aspects of my practice that had been of concern to the reviewer.

Discussions with other colleagues

The changes to PDP from speaking with other colleagues were similar. Doctors mentioned being more focused, particularly on changes relating to other colleagues such as peer review, speaking with colleagues and attending practice meetings.

More focus discussion with Peer review group.

Got good ideas on what was available as a semiretired locum.

Discussions with managers/employers

Comments focused on administrative tasks, training and changes in practice management. A number of these did not appear to be actual changes to PDP management, but instead aspects of practice.

Discussed the need to have more time for some consultations and the need for peer review to be continued.

5.6.2. 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:[6]

- 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

[6] 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. More than half (58%) of the doctors who responded to the post-RPR survey had discussed the PDPs with their CRPs.

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, a specialist role, 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. There were a number of other examples similar to this whereby doctors and reviewers mentioned that not all CRP relationships were of much use.

> *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.

5.6.3. 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.

> *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.*

6. The RPR Reviewers

The reviewers have a key role in the RPR process. There were 30 reviewers active during 2015, an increase from 19 when the first reviewer survey was conducted.

Most doctors felt that their reviewer demonstrated appropriate skills to evaluate their practice, consistent with results from the previous reports. A perceived mis-match between the reviewed doctors' practice and the reviewer was a reason for dissatisfaction for some doctors. This arose more commonly for doctors in atypical practices.

Seventeen of the 22 reviewers who responded to the survey had been reviewers since the 2014 survey. Results from the 2016 survey were consistent with those from 2014:

- Almost all reviewers felt they had the necessary training, support and information about the doctor to be effective reviewers.
- More than half felt they were completing the right number of reviews, with just under one-third wanting more reviews and a very small proportion wanting fewer. About one per month was the most common ideal number of reviews.

Reviewers were confident their feedback led to changes in practice that would improve care for patients. However, they were uncertain whether those changes took place because they did not have any follow-up contact with doctors. Giving feedback is a skilled role. Developing the reviewers' ability to provide feedback on opportunities to develop the reviewed doctors' practice could 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 that they are effective as reviewers even when the doctor being reviewed has a different scope of practice to their own
- How to provide feedback and advice that would assist RPR doctors to use information from the review to make changes.

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

6.1 The responding reviewers

The first reviewer survey was completed at the end of 2014, relatively early in implementation of RPR. There were 19 active reviewers and all completed the survey. The survey found that:

- Many reviewers were new to the role and it was still developing. Some had experience in similar roles in New Zealand and overseas, but it was the first reviewer role for others.
- Reviewers felt well supported and were positive about the training they received, but were interested in further developing their skills (particularly how to provide feedback and advice to best promote change).
- Most reviewers agreed participating in RPR would enable doctors to make changes to their practice and improve the care they provide for patients.
- Reviewers wanted feedback and confirmation they were effective in their roles and that RPR as a whole was leading to positive changes in practice for the participating doctors.

The number of active reviewers increased to 30 for this second reviewer survey. Of those 30 responding reviewers, 13 were new and 17 had continued in their roles since 2014.

Almost all (93%) of the reviewers are still in clinical practice. The three reviewers not in clinical practice had been out of practice for three, 25 and 33 years respectively. Most of the reviewers had between 20 and 40 years of practice.

6.2 Participating doctors' perspectives

Doctors accepting the reviewers as knowledgeable and experienced enough to review their practice was an important factor in their satisfaction with RPR. The match between the reviewer and the reviewed doctor in terms of seniority and area of practice were often mentioned by participating doctors as reasons for their satisfaction or dissatisfaction. In the post-RPR survey, most felt that their reviewer demonstrated appropriate skills to evaluate their practice (Figure 23).

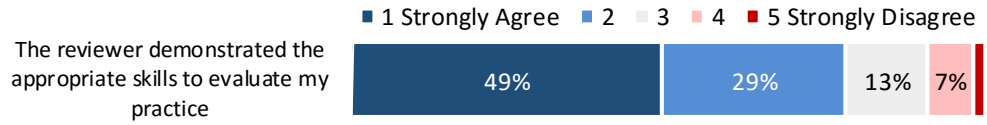

Figure 23. Responding doctors' views on the reviewers' skills (n = 194).

The proportion of the reviewed doctors who thought the reviewer demonstrated appropriate skills increased from the first half of 2014 (note low response numbers) and remained steady since (Figure 24).

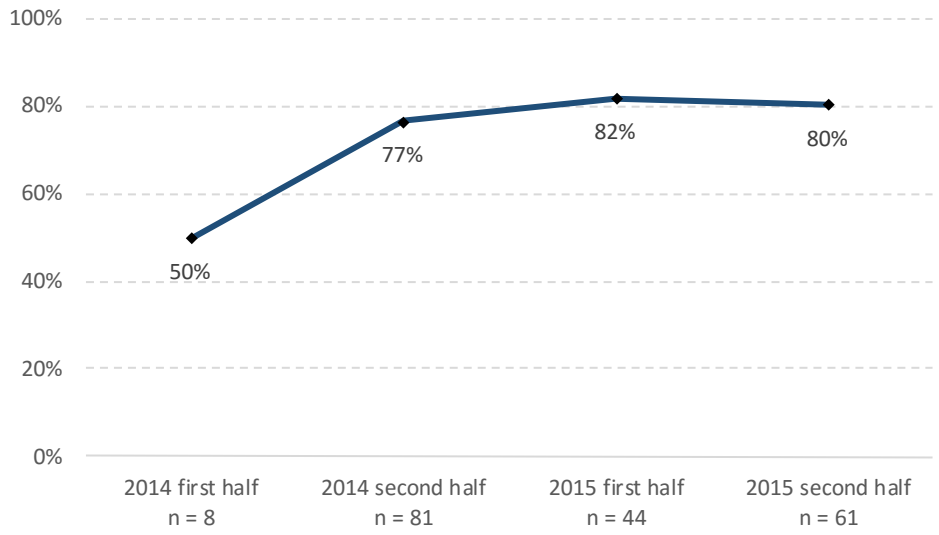

Figure 24. Proportion of post-RPR survey respondents who agreed or strongly agreed that the reviewer demonstrated appropriate skills.

Where the reviewed doctor did not see the reviewer as suitable there was often dissatisfaction with the experience as a 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 of the reviewed doctors recognised that the reviewer could comment on the general aspects of their practice even if they were not experts in their specific area of practice.

Having a senior reviewer was also valued.

> *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.*

There were some comments from a small minority of doctors who felt their reviewer's conduct had been inappropriate, unrelated to the reviewed doctors' perception of the reviewers' knowledge and experience. There were two themes: a small number of doctors saw the reviewer as unprofessional due to the way they managed the practice visit (lateness, informality). For example:

> *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.

A small number of other doctors commented on their reviewer's conduct in consultations, for example commenting or sighing in the presence of patients.

6.3 Reviewer training and preparation

RPR reviewers felt they had the necessary support and training to carry out effective reviews and had sufficient information about the doctor being reviewed. None disagreed with any of the three statements (Figure 25).

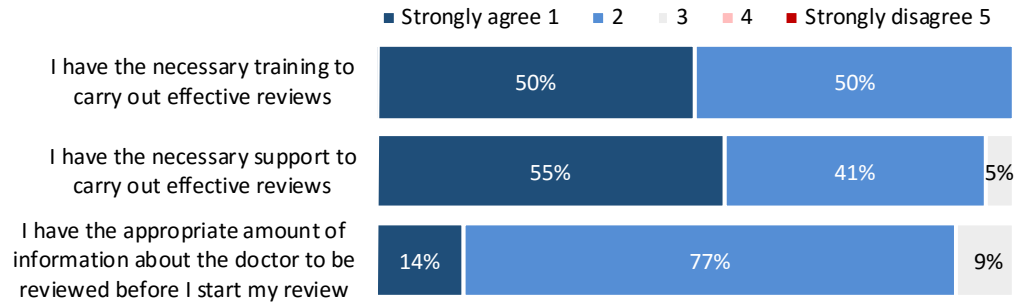

Figure 25. Reviewers' views on their preparation for the reviewer role (n = 22).

All reviewers interviewed thought that the support they received to do the role was very good. Reviewers were happy with being able to call bpac^{nz} and ask questions. They thought the communication was prompt and simple to follow.

Reviewers reported the training sessions and material for the role were well organised and useful, and that 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.

6.4 Reviewer workload

More than half (59%) of the reviewers thought they were completing about the right number of reviews, while ideally one-third (32%) wanted to complete more reviews in the next 12 months than in the past 12 months (Figure 26). Whilst 9% of the reviewers wanted fewer reviews.

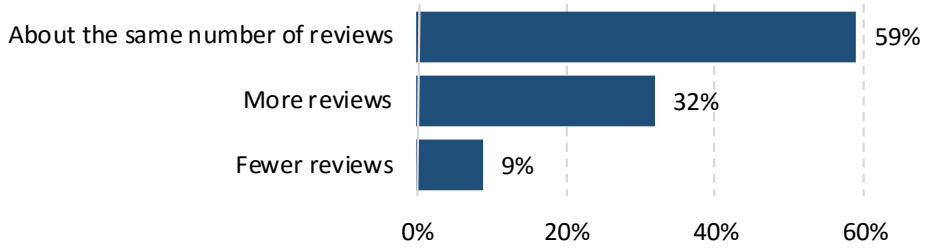

Figure 26. RPR reviewers' views on if they would like to do more reviews in the next 12 months (n = 22).

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

6.5 Reviewers' perspectives on doctors' reactions to RPR

RPR reviewers reported that they were positively received by doctors. Most agreed that doctors were receptive to the practice visit and the reviewers' feedback (Figure 27). Compared to 2014 survey, a smaller proportion of reviewers strongly agreed with each statement and a higher proportion agreed.

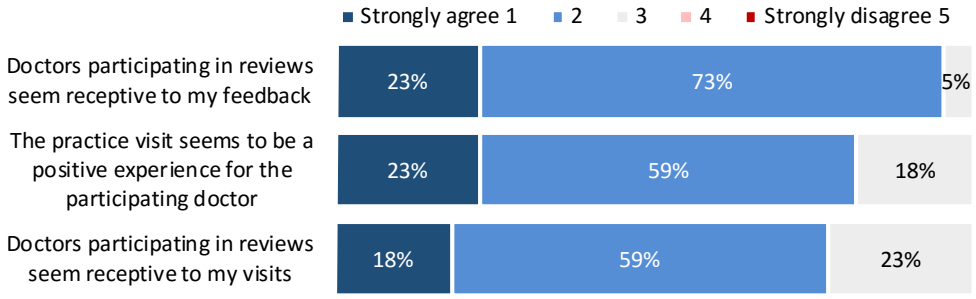

Figure 27. Reviewers' views on doctors' reactions to RPR (n = 22).

Reviewers were also positive about the perception of reviewers by the sector as a whole (Figure 28).

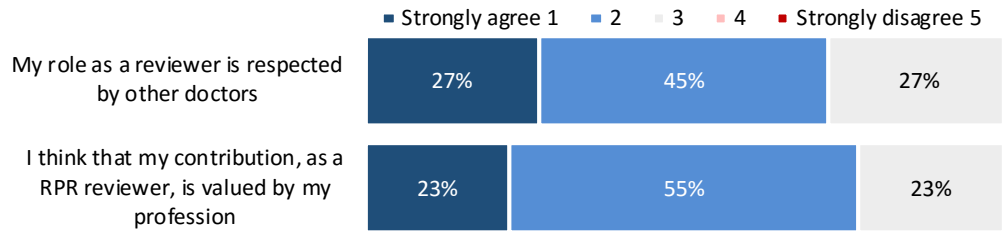

Figure 28. Reviewers' views on the perception of them among other doctors (n = 22).

6.6 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 29). As in other areas, smaller proportions of reviewers strongly agreed with each statement.

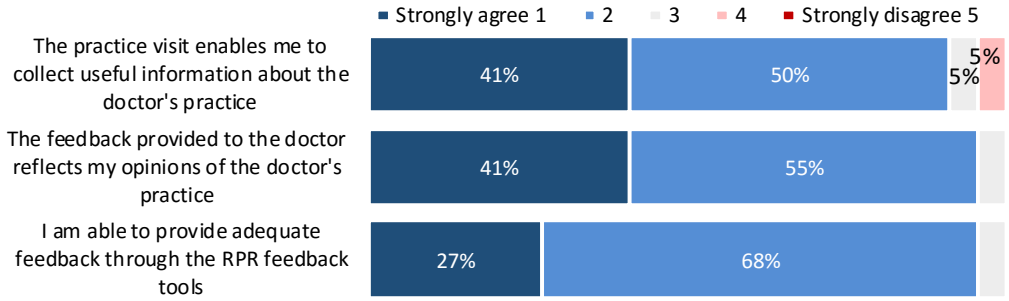

Figure 29. Reviewers' views on the practice visit and feedback to the reviewed doctors (n = 22).

All the interviewed reviewers found the practice visit very useful. As in the 2014, most described the 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 addressing the perception of RPR as 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.*

Since the last survey, a new RPR report template was introduced. All of the interviewed reviewers thought the new report allowed them to say what they needed and covered enough areas. The only suggestion for improvement, from one reviewer, was that there may be some scope to reduce repetition.

All reviewers thought that 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.

6.7 Views on RPR's effectiveness

Most reviewers thought RPR would enable doctors to make changes to their practice (Figure 27). A lower proportion thought RPR contributed to improving the care delivered to patients. A slightly higher proportion of reviewers agreed with each statement in the 2015 survey compared to the 2014 survey, however reviewers were less likely to strongly agree.

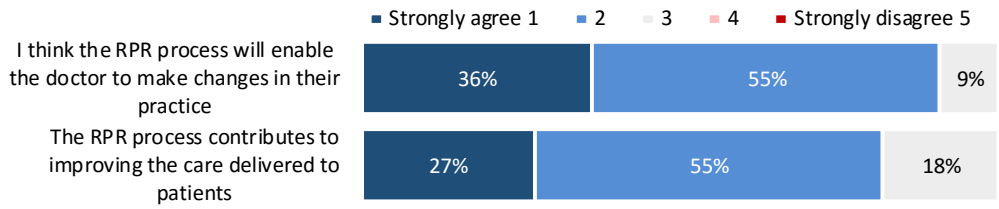

Figure 30. Reviewers' views on whether RPR contributed to changes in practice and improvements in care delivered to patients (n = 22).

As noted above, reviewers thought doctors were receptive to feedback and were therefore confident their feedback would lead to practice changes. However, not all were sure doctors would make changes to their practice. The uncertainty most often related to not having any direct feedback from doctors or follow-up with the doctors after RPR. They therefore had no way to be sure that there were actual improvements.

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 gage 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 commented that they thought more experienced doctors might be less likely to change their PDPs because:

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

6.8 Benefits for reviewers

Reviewers were positive about their roles with all reviewers surveyed agreeing that the role has been a positive experience and that the role has improved their own practice (Figure 31).

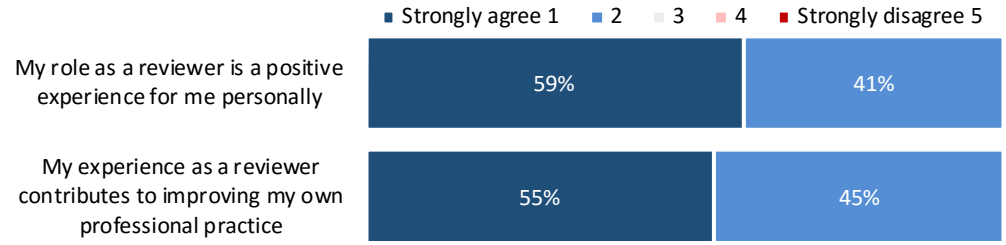

Figure 31: Reviewers' views on how positive the role is and if it contributes to their own practice (n = 22).

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

> *Watching others, it's a real privilege, and I've got lots of ideas form people and seen things that are great.*

Reviewing doctors in other areas of practice was a good way for reviewers to expand their knowledge. However, reviewers' comfort reviewing doctors in different areas of practice varied. Some thought they should only be reviewing doctors in their specific area of practice.

> *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.*

> *Going to another department that you haven't been to before, it's always good to see other ways of doing things and to see someone else doing the job and then feeding back it makes you reflect on what you do.*

6.9 RPR reviewer suggestions for improvement

Reviewers made a range of suggestions for both strengthening the RPR programme and for improving the reviewer role.

Suggestions for improving the reviewer role include:

- Having more feedback: This was a common comment in 2014. While it was less common in 2016, some reviewers still expressed a desire for more personal feedback from the reviewed doctors on how they could improve and what helped.
- 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 that when there was a significant amount of travel required, extra time and overnight accommodation could be appropriate.

Suggestions for improving RPR in general included:

- Strengthening the PDP system: Some reviewers commented that making the PDP system more straightforward would make it easier for doctors to use and for them to provide advice to doctors. Many said that the reviewed doctors did not understand the process of making an effective PDP.
- CRPS: Giving the CRPs a more formal role in RPR could strengthen the relationship between the CRP and the reviewed doctor and give the reviewer a more complete picture of the reviewed doctor.

Reviewers have contact with the collegial relationship provider prior to the review visit as well as having a pre-visit discussion with the doctors to outline the process. Some reviewers mentioned that an email could be just as effective as a phone call, but some doctors and reviewers advocated for phone contact to begin building rapport.

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

6.10 Variation in response to reviewers

Post-RPR and twelve-month survey responses have been linked to their reviewers. Looking at post-RPR survey responses by individual reviewer highlights differences across reviewers (Table 6). The analysis highlights the link between RPR outcomes and the reviewers completing the reviews.

Table 6. Cells show the percentage of doctors with positive results in each area. Each row represents doctors' feedback about a group of reviewers (roughly one-third, grouped by the proportion of their reviewed doctors who reported changes in practice). Only reviewers who reviewed at least five survey respondents are included in the table.

Reviewers	Doctors who made practice changes	Reviewer demonstrated appropriate skills	Practice visit was a positive experience	The report identified new areas for development	Doctors who have made PDP changes already	Doctors who would recommend RPR
Top tier n = 4	86% (82-91)	86% (82-100)	74% (69-82)	67% (63-82)	79% (73-85)	85% (73-92)
Mid tier n = 5	80% (67-100)	75% (50-100)	60% (60-60)	70% (33-80)	60% (42-80)	60% (50-80)
Low tier n = 7	67% (50-92)	60% (46-92)	31% (13-36)	44% (20-47)	27% (23-44)	50% (13-73)

Reviewers in the top tier had the highest proportion of doctors reporting changes in practice, along with the best results in all other areas with the exception of identifying new areas for development. Those in the low tier had the lowest proportion of positive responses in all areas.

It is important to note that some of the difference across reviewers may result from non-random allocation of the doctors to be reviewed, or from the characteristics of the reviewed doctors. 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.

As more doctors complete the twelve-month survey and more doctors in other areas of practice complete RPR, it will be possible to look at review results by these data as well.

7. Conclusion

7.1 Evidence based

The RPR design is based on evidence. The literature summary provided in previous reports highlighted evidence that audit and feedback can improve practice and patient outcomes:

- Audit and feedback generally lead to small but potentially important improvements, 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 (Jamtvedt et al., 2012).
- Multi-source feedback can lead to performance improvement but the context and facilitation of the feedback were influential on the degree of improvement (Miller and Archer, 2010).
- 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 (O'Brien et al, 2008).

7.2 Doctors are reporting making changes

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. Twelve-months after their RPR, just under half of the participating doctors continued to report changes in practice. The changes they described are likely to improve outcomes for their patients.

Post-RPR, doctors were more likely to have made changes if they were working as GPs, had English as a second language, and/or they learned new development opportunities in their RPR reports. Doctors who were trained outside New Zealand were more likely to recommend RPR to their colleagues than New Zealand trained doctors.

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

7.3 Change 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 data available are still limited. This area of the evaluation will continue to be developed as more doctors complete RPR.

7.4 The 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 ways that are 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.

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 therefore 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 general practice, new reviewers in other areas of practice have been employed, including obstetrics and gynaecology, internal medicine, emergency medicine and psychiatry.

Some reviewers liked reviewing doctors outside of their speciality. 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.

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. As noted above, 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.

7.5 Strengthening the programme

Surveys and interviews suggested some aspects of the programme 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 and in the lead-up to the review about how the schedule for the day would be modified to suit their practice could ease concerns and allow the doctor to be adequately prepared.
- Follow-up after the review. Reviewers were positive about having some follow-up with the doctors they reviewed, to support practice changes and see the result of their work.

7.6 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. Additional completions will facilitate time-series analysis.

Analysis of bpac^{nz} data on professional development plans will be incorporated into the next report, which will be provided in mid-2016.

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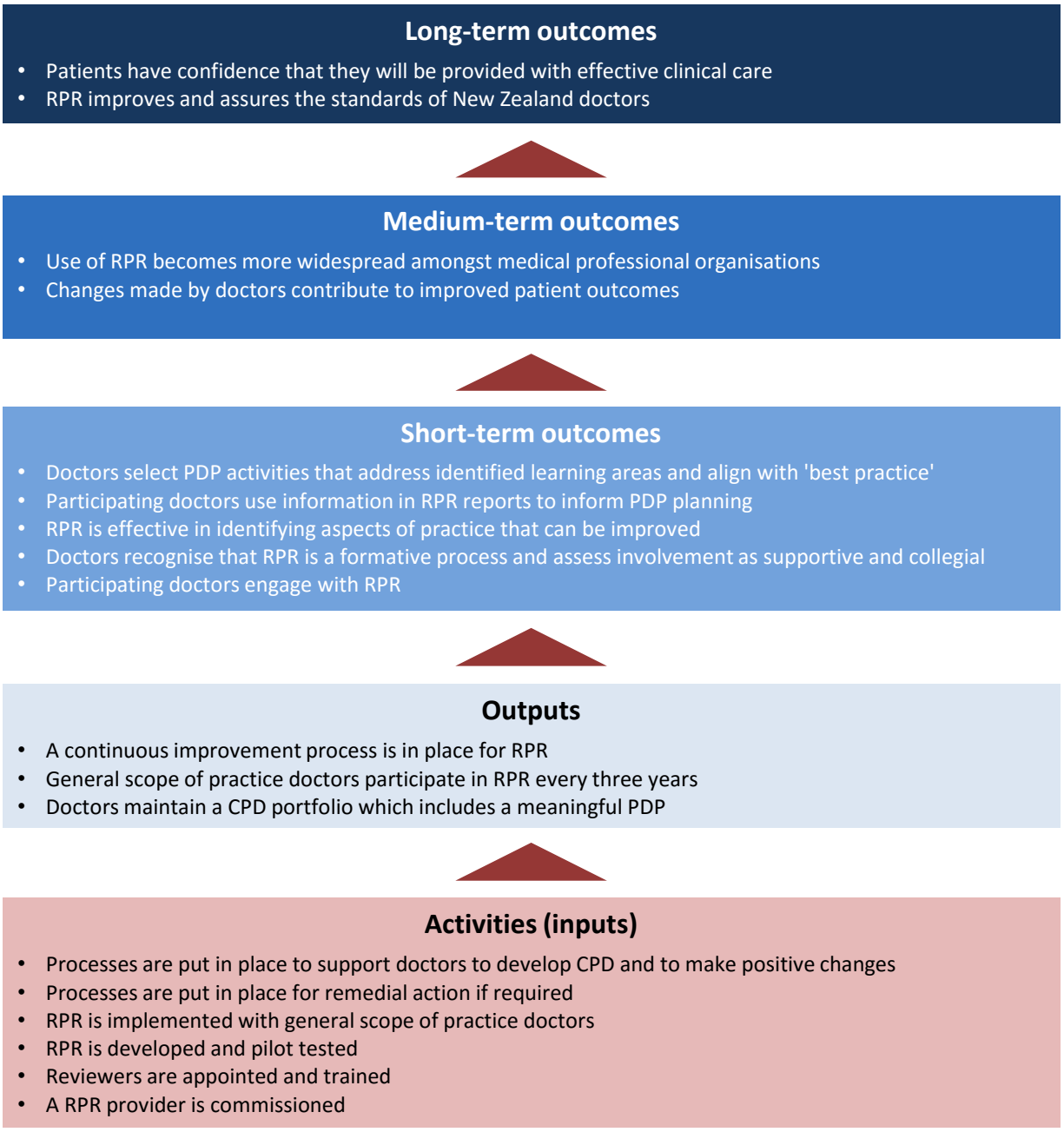
Appendix One: Logic Model and Evaluation Framework



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

Evaluation Framework

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