

Regular Practice Review trials.

Executive Summary and Conclusions.

Member Learning and Development

Office of the Dean

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# PART A: Overview and recommendations

# Executive summary

The Royal Australasian College of Physicians has developed a framework for Regular Practice Review (RPR) with a view to recommending it to Fellows as required by the Medical Council of New Zealand (MCNZ). The development of an RACP framework was prompted by the College:

* Seeking a review framework that was Fellow driven and focused on the review and development of an individual’s practice in the context of the health service they work for.
* Recognising that the RPR format established by the MCNZ for general registrants (ie. a one-day practice visit) was not sustainable given the numbers of Physicians.
* Ensuring the compliance burden on Physicians is reduced rather than expanded.

The framework the RACP has developed has two components:

1. The individual annual Professional Development Review (PDR).
2. The three-five yearly unit level Service Development Survey (SDS).

Initial trials of the framework were held in 2013 and resulted in revisions and development of support materials.

In 2016/17 three new trial sites at medium sized regional hospital units in New Zealand were established through the relevant Heads of Department (HoDs) agreeing to participate. The trials were managed by the RACP Learning Support Unit (LSU) with advice from relevant Fellow led committees (the Practice Review Support Working Group, The New Zealand Continuing Professional Development Committee and the RACP Continuing Professional Development Committee).

One site did not begin the trial due to unforeseen work pressures on the HoD. Nineteen Fellows at the other two sites trialed the individual PDR process. One site trialed the unit level SDS.

## 1.1 Professional Development Review (PDR):

Similar to the trials held in 2013, most participants were positive about the PDR and the outcomes. However, the positive response was not unanimous and a minority considered it overly complicated, intrusive, and a waste of time.

One of the key goals in developing an RACP format for RPR is to meet the MCNZ’s requirement for Medical Colleges to recommend a framework for practice review. A significant question that remains is whether the external review element required by the MCNZ (but not present in these trials due to difficulties in organisation) will be sustainable for PDRs when rolled out more broadly.

Most participants:

* Reported the PDR was worth the time it took.
* Identified value in the encouragement to reflect on their practice and the structured opportunity to plan the year ahead with senior colleagues. Many mentioned it is possible to do this individually but it is unlikely to happen without a formal process.
* Reported identifying changes they intended to make to their practice. However, only a few reviewees identified specific changes they intended to make and most of these were in the professional realm (such as time management, leadership development, workload adjustment, self-care etc). One reviewee identified a specific clinical need to upskill and reported organising to attend a workshop to meet that need. Another mentioned identifying the need to address an immediate standard of care issue (not specified).
* Reported that the ‘PDR form and interview’ (the PDR) were superior to other forms of formal review they had completed and the PDR gave them an opportunity to represent their practice accurately.
* Supported the value of having two reviewers with at least one of these being from their specialty and at least one being from the unit they work in.
* Agreed the PDR should be repeated annually and would recommend participating in a PDR to other physicians.

Other findings include:

* While there is a small majority of the trial group that believes the PDR has the potential to realise practice change, this evaluation does not provide evidence to support whether practice change occurred and follow up surveys and further research is required to provide this evidence.
* Confidentiality of the information provided by reviewees raises significant sensitivities with some respondents clearly in favour of the contents remaining between the reviewers and the reviewee while others believed it was useful for the information to be made available to the employer organization for such processes as credentialing.
* Issues were raised by a minority of respondents about appropriateness of some health related questions in the PDR form.
* Most reviewees agreed the PDR Process provides an opportunity to talk about how the organisation affects their job and it is clear there is room to improve how the PDR addresses this question.
* Five reviewers provided feedback. They agreed the PDR was an effective way of reviewing an individual’s practice, it was worth the time it took and that it should be repeated annually.

On average completing the PDR form took 1.2 hours (ranging from 30 mins to several hours) and on average the PDR interview was one hour (range 30 – 90 mins). For both the report and the interview, most respondents found this time to be ‘about right’.

## 1.2 Service Development Survey (SDS):

An SDS was conducted at one trial site and involved one Head of Department reviewee and two external reviewers. The SDS was done in conjunction with Hospital credentialing for the unit and this did make evaluation of the SDS difficult. All three participants did see some potential for the SDS process independently, and potential for combining the process with credentialing. However, two of the three participants found the combination of the SDS and credentialing to be a confusing factor and all three recognized there was a need for a significantly improved implementation of the process. There was confusion about how best to include information from individual PDRs into the SDS and confusion caused by the different aims, and different participants, of credentialing and the SDS.

The trial indicated a need for further development of the SDS process, form and support materials and significant further testing is required to ensure an effective process. The trial identified a need for: better preparation and training of participants; instructions that are simple and that outline how to combine the SDS and credentialing, and a review of the SDS form.

## 1.3 DHB/RACP meetings held in 2017

The RACP Dean, Professor Richard Doherty and Professor John Kolbe, convened meetings on 27 and 28 September 2017 with clinical and HR representatives from a number of north and central North Island DHBs. The Meetings included two Fellows who had been involved in the RPR trials. The focus of these meetings was to:

* Outline work done to date, including an outline of the College RPR and MSF trials.
* Further determine what the regulator, employer and College are looking for from a performance review framework and to identify more specifically where requirements overlap and can be met by one tool.

The meetings provided ‘in-principle’ support for the concept of using a review tool that facilitates the gathering of information by Fellows once that can be used to meet the bulk of requirements of the regulator, colleges and employers. Issues identified included sustainability, privacy and ownership of information, need for IT systems to support information protection and sharing, current inadequacy of data sharing, and the lack of clarity around the various responsibilities when those ‘at risk’ of underperformance are identified. DHB’s at the meeting expressed a desire to be involved with the College in continuing trials and developments.

The Office of the Dean has used the data from these meetings and the feedback from the RPR trials to review and adjust the current PDR form (Appendix 1) and the SDS form (Appendix 2).

# Recommendations

That the NZ CPD committee:

1. Review and further adjust as required the revised PDR and SDS forms (Appendices 1 and 2)
2. Identify further sites to trial the revised PDR form and in particular:
	1. Include at least one site that does not currently complete annual performance reviews.
	2. Ensure all trial sites include an external reviewer (even if from another unit within the same service) for at least some reviewees.
	3. Ensure trial sites require reviewees to bring evidence of peer review activities to the PDR meeting.
3. Identify from the sites above - sites to trial the SDS:
	1. Together with credentialing.
	2. Separate from credentialing (ie who are at a midway point in their credentialing cycle or who are a year out and want to run a formative process as part of preparation).

# RACP Regular Practice Review (RPR)

RPR is a supportive and collegial review of a doctor’s practice by peers. RPR provides a framework for physicians to receive peer driven feedback that has the potential to improve their own practice, the practice of the service they work in and to improve the existing high standard of the profession. It is designed to assist good physicians to improve their practice and good health services to improve their standards of care.

RPR can take different forms but is designed to facilitate:

* reflection upon past practice and informed planning for improvement
* feedback from peers, presented in ways most likely to be effective in improving performance
* personal professional development and workplace improvement
* early identification of underperformance
* early identification of the risk of underperformance

The focus is on the needs of the individual doctor including their self-care and health. It is designed to identify organisational factors that either support or hinder the doctor in their work and development.

A key outcome is an individual’s updated Professional Development Plan – not a score or a rating.

In an RPR the candidate and the employing organisation share responsibility for the outcome. The bulk of information remains confidential to the candidate and reviewers. However relevant information may be shared with the employing organisation to allow it to assure the capability of its workforce. Any information that may be shared is clearly identified in the PDR form.

## 3.1 Principles [[1]](#footnote-1)

Key principles of RPR include that it:

* is a formative, supportive and collegial review of a doctor’s practice by peers
* is a quality improvement process
* provides an assessment across the domains of competence outlined in Good Medical Practice focusing on the area in which the doctor works
* includes multisource assessment and a component of external assessment, that is by peers external to the doctor’s usual practice.

## 3.2 Background and structure of the RACP regular practice review[[2]](#footnote-2)

The RACP New Zealand CPD Committee began developing an RPR framework in 2010. In developing the framework, it consulted with a number of other medical colleges, associations and societies. Members from RACP’s Divisions, Chapters, Faculties and the Māori Health Committee have also contributed to the development of the materials.

The motivation for the development of the framework included:

* Recognition that the process of RPR designed by the MCNZ for those in a general scope of practice (ie. a one day practice visit) is not sustainable for the College.
* The desire to develop a whole systems approach that examines how an individual is functioning within their work place/s.
* The need to implement a process within current work places with minimal disruption to the doctor’s clinical practice.

The framework has two interlocking parts. Each RPR consists of both an annual ‘professional development review’ (PDR) of each Fellow within that service or department and an overarching ‘Service Development Survey’ (SDS) that will occur every three-five years.

The first phase involves the reviewee/s in a service or department completing a PDR form. Each reviewee will send the completed form to two nominated reviewers and organise to meet with them. The PDR includes peer review and clinical audit activities, but it also collects much richer information allowing the reviewers to gain insights into the candidate’s current work commitments (both clinical and non-clinical) and their future aspirations.

The completed PDRs from each individual then inform the SDS.

The SDS outlines the key elements of the health services provided including the frameworks for managing, supporting and developing the Fellows working in that service. Two external reviewers are central to each SDS. The SDS may coincide with and be completed in conjunction with credentialing or it could be done in between credentialing exercises.

# PART B: Trials

# The Professional Development Review (PDR)

## Discussion.

The trial was conducted at sites that had volunteered to participate. It included clinicians who already have annual performance reviews so the concept of review was familiar. A high number (14 of 23) indicated they had a professional development plan in place prior to the PDR and they were generally positive about what the PDR could offer. While the data produced is very valuable in terms of the further development of the RPR framework it is not possible to generalise the results broadly given the size of the sample and the generally positive nature of a sample of clinicians already engaged in annual reviews. Anecdotally these conditions are not widespread.

The one trial site that does not currently have annual performance reviews did not complete any PDRs due to the pressure of other priorities. This indicates that introduction of tools such as RPR that have an annual component are much easier to introduce if a culture of regular review is already established.

The form used and the interview process (2 reviewers) was generally supported by all participants (reviewers and reviewees) and was acknowledged as better than others that participants had participated in. Reviewees identified the need to eventually have an on-line form to which data can be downloaded and this needs to be included in future PDR form and MyCPD development.

Clearly, Fellows prefer a process that is College lead and endorsed. Improvements were suggested to the PDR form, particularly in relation to removing some of the extra health related questions used at one of the trial sites, but also introducing questions that may cover more directly issues such as potential burn-out. The trial does however demonstrate that the PDR form and process is likely to have a reasonable level of support from Fellows in New Zealand.

On average completing the PDR form took reviewees one hour and 12 minutes and on average the PDR interview was one hour. This time frame was generally seen as manageable by reviewees and is less of a time commitment than some other forms of Regular Practice Review such as a practice visit. The time calculated does not, however include the time required to complete peer review/audit activities that are an essential component of a PDR but that were not included in this trial as it was the first round of PDR’s for both trial sites. It will be necessary to reassess this after the sites complete a second round of PDRs.

Reviewers raised a number of questions about the challenges associated with managing poor reviews and the potential for identifying underperformance. Guidelines about how this is to be handled are not in place and need to be developed.

Other questions that data from the trial raised include:

* **The challenge of sustainably including external peer review**. External review is a key principle of MCNZ RPR. External peer review is designed into the PDR in two ways:
	+ Firstly, through the requirement for one of the reviewers to be external to the unit of the reviewee. Thisonly occurred when HODs were reviewed by senior Hospital Staff. Otherwise all reviews were done by ‘in-service’ Fellows/administrators. It is essential that external review occur for at least some reviewees each round and that over the course of an RPR cycle each Fellow of the unit participates in a review that includes an external reviewer. This has significant logistical impacts for health units.
	+ Secondly, through the requirement for reviewees to bring evidence of the peer review activities they have completed. This occurred rarely and needs to become a core part of the PDR process to ensure that external review of the reviewees’ practice is being undertaken and that necessary action is occurring in response.
* **The need for the feedback loop to be closed**. Feedback from reviewees indicates this needs to occur in two ways. Firstly, through the completion and return of a copy of the PDR feedback summary and secondarily through the inclusion of a review at the next PDR of what was agreed to by both reviewee and reviewers and what was achieved. Without this feedback loop the likelihood of change occurring will be limited.

The trial demonstrated a high degree of support for the PDR with the primary outcomes identified as the opportunity it provides for reflection on practice, discussion around the organizational impacts on practice, and planning for the future. While a majority (14 of 17) indicated they thought it would contribute to changes in their practice the trial was not set up to provide evidence to support this. Change in practice is difficult to measure and follow up surveys and further research is required to provide this evidence.

A clear tension that emerges from the trial is between the confidentiality of the information provided by reviewees and the value in using the information provided to support processes such as credentialing. The trial indicates that most respondents would potentially alter the information they included in the PDR form and interview if the process had a summative element and/or the information was available to employers or regulators.

## Conclusion

The trials of the PDR demonstrate that where annual review processes are established, unit leadership is supportive and engaged, and significant trust exists between staff and management, the PDR provides an effective annual review tool. The positive response from reviewees and reviewers indicate that the PDR form and process is likely to meet the annual review needs of a large percentage of NZ Fellows.

Based on feedback from the trials and the RACP/DHB meetings held in 2017 the PDR form has been substantially reviewed. Further trials to establish the efficacy of these changes is required.

# The Service Development Survey (SDS)

## Discussion

The three Fellow participants in this review all indicated the potential value and effectiveness of the SDS. The combination of the SDS with the credentialing of the unit complicated the evaluation and while there was qualified support for this combination, the need for substantial change in the preparation, process and tools was identified.

Because of the difficulty separating the impact of the SDS from the credentialing, the trial has not produced a clear evaluation of the SDS as a completion of the PDR process resulting in a comprehensive Regular Practice Review of the physicians in a unit. There was certainly evidence that it is possible for the SDS to achieve this goal however this trial was not conclusive in this respect.

There was agreement that the objectives of the SDS and credentialing overlap but are not completely duplicated. The SDS has an internal focus on the individual physicians and how their work is impacted by the unit and hospital service. Credentialing has an external focus on the way the unit and clinicians are meeting the needs of the hospital service. Both have the potential to identify areas for improvement at the unit level and at the individual clinician level although one reviewer believed strongly that credentialing was the more robust and more likely to identify clinician performance issues.

It was clear from the HoD feedback that in this case the combination of the SDS and credentialing did not limit the compliance requirements but increased them. While it was hoped the SDS would cover information required for credentialing this was not the case and the HoD completed both forms.

The confusion discussed by the HoD and one of the reviewers indicates the need for much more significant preparation and guidance of the HoD, reviewers and credentialing panel to ensure a smooth process.

## Conclusion

Further trials of the SDS are required both together with and separate from credentialing. Trials separate from credentialing will provide evidence of the value of the SDS as a standalone exercise and will be necessary to finalise development of the RPR process to meet MCNZ requirements.

1. Amended from <https://www.mcnz.org.nz/assets/Policies/Policy-on-regular-practice-review.pdf> [↑](#footnote-ref-1)
2. Adapted from the Report on Regular Practice Review Pilot 2013 prepared by Rosemary Matthews. Senior Executive Officer, New Zealand Office. Dec 2013. [↑](#footnote-ref-2)