

REPORT ON REGULAR PRACTICE REVIEW PILOT 2013

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EXECUTIVE SUMMARY

1.1 Introduction and Context

1. The Royal Australasian College of Physicians has developed a Regular Practice Review (RPR) framework in response to the Medical Council of New Zealand's policy, articulated below:

We are encouraging the profession to lead development of the RPR process. For those who are registered in a vocational scope, these processes are being made available as part of continuing professional development programmes through branch advisory bodies (BAB). RPR is not compulsory and is not required for recertification for these doctors.... Council will encourage each BAB to develop a RPR process using specific tools relevant to that specialty. Alternatively they may expand upon existing BAB processes or tools that have already been developed by Council. BABs will make the process available to doctors on a voluntary basis¹.

2. The RPR is but one mechanism for assessing professional standards. Other complementary methods include performance and planning reviews, focusing on aspects of practice within the previous year, and planning for the following year, and credentialing, which includes scopes of practice. All of these quality improvement and professional development modalities are strongly influenced by the context within which a health professional is practising.
3. *The Credentialing Framework for New Zealand Health Professionals²* discusses the roles of regulatory authorities, and of professional colleges and specialist societies, and defines credentialing as: *a process used by health and disability service providers to assign specific clinical responsibilities to health practitioners on the basis of their education and training, qualifications, experience and fitness to practice within a defined context. The context includes the particular service provided, and the facilities and support available within the organisation³.*
4. None of the above mechanisms will guarantee safety and quality in the delivery of patient care, but they have the potential to improve them significantly.

Credentialing will not eliminate the occasional practitioner error; nor will it eliminate those very few practitioners who deliberately attempt to defraud the system. Credentialing manages risk by identifying system errors and individual practitioners with a pattern of poor performance. Its success relies on practitioners who engage in

¹ Medical Council Of New Zealand. 2010. "Regular practice reviews now a reality". *Newsletter of the Medical Council of New Zealand*. December 2010, no. 50, pp. 5-6. Accessed 3 December 2013 from: <http://www.mcnz.org.nz/news-and-publications/our-newsletter/>

² Ministry of Health. 2010. *The Credentialing Framework for New Zealand Health Professionals*, Wellington: Ministry of Health. Accessed on 3 December 2013 from: <http://www.health.govt.nz/publication/credentialing-framework-new-zealand-health-professionals>

³ Ibid.

self- and personal assessment. The process focuses on quality improvement rather than discipline: practitioners actively participate in the process as a means of measuring their professional accountability⁴.

5. The RPR developed by the College has elements of credentialing and performance / planning reviews and its focus is on quality improvement rather than quality assurance.
6. The pilot conducted at North Shore Hospital has been completed with feedback received from all participants in the Professional Development Review (PDR) and the Service Review.
7. This is a small scale pilot involving less than 30 participants therefore the data cannot be analysed using statistical methods. Twelve cardiologists participated in the PDR and four clinicians were involved in the Service Review pilot.

1.2 Professional Development Review - Participants' feedback on the Professional Development Review

8. The Professional Development Review (PDR) participants did not believe that the process was particularly time-consuming. Preparation for the PDR took approximately an hour and the interview with all participants reporting the duration of the PDR interview was "about right": In general the interview lasted between 45 minutes to an hour.
9. The feedback from the participants is that two Fellows from the same speciality do not have to be involved in the PDR process. Whilst there is consensus that one Reviewer has to be practising in the same specialty, the other Reviewer can be practising in another speciality or may not be a medically-trained individual.
10. Most participants supported the PDR's structure, noting it is "fairly logical".
11. The pilot did identify that some additional information was required prior to the PDR interview occurring. Five participants thought a "Completing your PDR document" factsheet would be useful, as not all Fellows would be familiar with this type of exercise. One participant stated "I think [it] would help our thought processes and planning". Six participants thought an FAQ factsheet would be useful.
12. This pilot is the first stage of an ongoing PDR process; therefore, the participants were unable to comment on all the components of the PDR.
13. Seven participants stated that the PDR section focusing on clinical activities e.g. maintaining clinical skills, clinical competence and cultural competence was the section that made the greatest contribution to practice improvement. The section on job satisfaction was also noted by six participants to be important in improving practice.

⁴ Ibid.

14. Overall, the participants affirmed that the PDR process has the potential to improve their practice. Some feedback includes:
- “Highlights both strengths and deficiencies and allows a frank discussion of potential solutions”
 - “Focuses on potential issues and also gives a chance to have a two-way discussion about other issueswhich may be difficult to broach in other less formal situations”
 - “Makes one feel supported”
 - “We often seem to be working individually but this process mandates group discussions and it improves collegiality”
 - “A good way of reviewing practice over a period of time and forces one to reflect on one’s work”.
15. The majority of the participants reaffirmed the Committee’s perception that the PDR is a formative process. One participant thought it was summative process and another thought it had summative and formative components. One participant commented that: “The PDR seemed far more constructive and self-directed than something coming from the outside and setting limits or mandatory goals”.
16. Participants were asked to give their views regarding who should retain the PDR information. Six of the participants thought that the PDR must remain confidential to the work place. One participant noted that a confidential interaction “allows more frank and open discussion” to occur. It can be concluded from this observation that allowing others outside the PDR process to view the PDR may reduce the potential for the PDR to improve practice. Three participants held different views: “possibility selected components could be made available to other parties”, or the RACP should perhaps hold the PDR. Two participants thought it was up to the “Reviewee to disclose it if desired or needed” or “Individuals could be asked [if they wanted to disclose the PDR]”.

1.3 Participants’ feedback on the Service Review

- 17 The Service Review clinicians agreed that at least two reviewers are required during a Service Review; however, they held differing views as to whether it was necessary for the Service Reviewers to be practising in the same medical speciality as the service / department being reviewed.
- 18 They were in agreement that external reviewers are essential, not only to meet regulatory requirements, but they add value by ensuring there is objectivity, independence from the organisation and they bring a different perspective to the issues raised within a Service Review discussion.
- 19 The Service Review lasted 90 minutes and the Service Review clinicians thought this was a reasonable amount of time.
- 20 Feedback from the Service Review clinicians indicates that some training is required to understand the process and what the expected outcomes from a Service Review are. A Service Reviewer noted: “I would want to receive education and guidance on the review content, processes and expectations so I could be adequately prepared for it”.
21. The objective of the Service Review is to provide an overview or macro view of the entire service. One Service Review clinician was not sure that this objective could be

achieved: "...there will be difficulties in finding reviewers to conduct the service review due to their own time constraints and work pressures. The Service Review interviews may not be too time-consuming but coordination of the whole review will be".

22. The Service Review clinicians concurred that implementing a Service Review in their department would change the way they did things and they all found attending the pilot Service Review a valuable experience. One Service Review clinician commented: "I enjoy knowing what motivates my colleagues and how they accomplish their goals"

1.4 General Comments and Feedback

23. The feedback from the pilot indicates that the process is a positive one and that both the PDR and Service Review contribute to practice improvement. The MCNZ clearly states its rationale for implementing a Regular Practice Review:

The primary purpose of RPR is to help maintain and improve standards of the profession. RPR is a quality improvement process .RPR may also assist in the identification of poor performance which may adversely affect patient care. 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 receive⁵.

24. The pilot has identified that additional support is required to ensure the PDR and the Service Review process are followed consistently by the reviewees and the Reviewers.

Table One: Additional Issues Identified in Pilot

Item Identified	Status	Assigned to
Developing a FAQs fact sheet	In progress	CPD Director
Developing "Completing your PDR" document	In progress	CPD Director
Training for Service Reviewers	Not progressed – requires further discussion	NZ CPD Committee
Developing a Service Review FAQ fact sheet	In progress	NZ CPD Committee

25. The Māori Health Committee representative has requested that tools are developed to assist the Reviewees in meeting cultural competency requirements identified in the PDR. The NZ CPD Committee and the Māori Health Committee have developed a multi-source feedback document based directly upon Supporting Physicians Professional Performance (SPPP).
26. The PDR needs to have one question added asking if the doctor has a General Practitioner to ensure the doctor is focusing on their own health and addressing self-care.
27. The Service Review requires a question regarding conflicts of interests e.g. does the Service maintain a conflicts of interest register.

⁵ The Medical Council of New Zealand. 2011. *Policy on Regular Practice Reviews*, 2011. Accessed November 2013 from: <http://www.mcnz.org.nz/assets/Policies/Policy-on-regular-practice-review.pdf>

28. The benefits of RPR and a brief summary of the findings from the pilot should be disseminated to the members via the RACP NZ Newsletter, the CPD Bulletin and the RACP News. The NZ CPD Committee will prepare relevant materials.

INTRODUCTION

The Royal Australasian College of Physicians (RACP) has developed a Regular Practice Review (RPR) framework in response to the Medical Council of New Zealand's policy on regular practice reviews⁶. The Medical Council of New Zealand (MCNZ) has mandated that doctors holding general registration must undertake a RPR every three years. The MCNZ strongly encourages vocationally registered doctors to participate in an RPR.

The New Zealand CPD Committee sought approval from the New Zealand (NZ) Committee, and the CPD expert advisory group (EAG) to design a Regular Practice Review framework. The NZ CPD Committee has been working on developing a framework since 2010. During that time the Committee consulted with a number of other medical colleges, associations and societies in developing its RPR framework. The result is a two-staged approach that can be implemented within current work places with minimal disruption to the doctor's clinical practice. The NZ CPD Committee's view was that the RPR could "become part of the wider hospital service review and will be funded by the hospital/DHB budget, not out of the individual's CME budget"⁷.

The RPR framework agreed upon by the RACP has two interlocking phases that comprehensively describe a service or a department. The Service Review is the overarching document, with the individual's Professional Development Review being one component of the Regular Practice Review.

The first phase of the Regular Practice Review involves the clinicians in a department / service completing a Professional Development Review (PDR) and then discussing the contents with another two clinicians or the Service manager. The PDR is attached as Appendix 1. The PDR includes peer review and clinical audit activities, which are MCNZ requirements, but it also collects much richer information allowing the Reviewers to gain insights into the clinicians' current work commitments (both clinical and non-clinical) and their future aspirations.

The completed PDRs then inform the Service Review. The Service Review outlines in broad terms the key elements of the health services provided by a particular service. For example, section one of the Service Review asks the service to identify any particular peer review groups in operation. These peer review groups should be identified in the individual's PDR, thus linking the two processes together. Conversely, if the service is running peer review groups and the individual's PDR does not record this information then this may be an indication that the service needs to investigate the reasons for its absence from the PDR.

The NZ CPD Committee has argued it is critical to examine not only how an individual is functioning within their work place, but a whole systems approach must be adapted if health services are to be delivered at an optimal level.

The NZ CPD Committee was interested in the logistics of undertaking a PDR, therefore a pilot was undertaken at the Cardiology Department of North Shore Hospital (NSH), This was

⁶ The Medical Council of New Zealand. 2011. *Policy on Regular Practice Reviews*, 2011. Accessed November 2013 from: <http://www.mcnz.org.nz/assets/Policies/Policy-on-regular-practice-review.pdf>

⁷ NZ CPD Committee Meeting Minutes, 16 November 2012.

a sample of convenience as the Clinical Director, Dr Tony Scott, is also the Chair of the NZ CPD Committee.

The pilot included the implementation of the PDR. An evaluation of the tools and the process was undertaken focusing on the value and acceptability of the PDR. The Service Review process was also assessed by three physicians external to NSH. This initial trial involving the Service Review and a number of PDR was performed on 5 April 2013. All participants involved in the PDR and Service Review were invited to complete a relevant questionnaire. The feedback from the questionnaires has been analysed and forms the basis of this report. The Pilot's findings will be used to inform decisions with regards to the Practice Review project.

RESULTS OF THE PILOT HELD AT NORTH SHORE HOSPITAL

The Pilot Setting

The Cardiology Department at North Shore Hospital (NSH), is a moderate-sized subspecialty department in a metropolitan hospital, based in the greater Auckland area. The cardiologists within the department include relatively new graduates, overseas trained physicians and others with extensive clinical governance experience.

The Professional Development Review (PDR) Pilot

Eleven cardiologists practising at NSH participated in a PDR pilot between April – September 2013. A PDR was completed by each individual participant and then during a face-to-face interview with the Director of Cardiology and the Manager of Cardiac Services the PDR was discussed in detail. On average the PDR interview lasted between 45 minutes and an hour. The Clinical Director at the Cardiology Department envisages a PDR interview would occur annually with all cardiologists practising in the Department.

By the end of September 2013, all participants had completed a PDR interview. A feedback questionnaire was then sent to eleven⁸ participants to elicit their feedback on the process. Feedback was received from all eleven participants⁹ and overall the response regarding the PDR tool and the process was positive. Two of the PDR interviews were conducted with two external physicians present (neither were cardiologists but they also practice in large urban hospitals) on 5 April 2013.

The objectives of the PDR pilot were to:

- a. Ascertain if the PDR process is feasible within a hospital setting. The feedback questionnaire asked the participants to reflect upon the structure, content of the PDR and role of the reviewers. The two external Reviewers were also invited to participate in the review process, and to observe the process and note if any amendments were required to the process.
- b. Ascertain if the PDR, in the opinion of the participants, contributes to practice improvement
- c. Identify if additional information is required to assist participants in completing a PDR
- d. Gauge the participants' views regarding the confidentiality of the information recorded in the PDR, and who should have access to the material.

Preparing for the PDR Interview

The participants reported that preparing the PDR interview took between 30 minutes and one hour. This information should be considered with caution as the PDRs completed in this initial pilot did not include data relating to all components of the PDR. For example, many participants had not conducted a Multi-source Feedback exercise, therefore these data could not be considered within the PDR framework. These omissions significantly reduced the time the participant was required to collate documents in preparation for the interview.

⁸ Dr Scott's feedback was not included due to research bias as he developed the Regular Practice Review process being evaluated.

⁹ One participant only completed the final question in the questionnaire therefore n=10.

When the PDR process is repeated in 2014 it will be more time-consuming for both participants and Reviewers as it is anticipated that most of the PDR components will be completed, thus increasing the preparation time and the duration of the interview.

The majority of participants indicated they wanted to access the PDR online, rather than complete the form in hard copy.

All the participants were of the opinion that the duration of PDR interview was “about right”: In general the PDR interview lasted between 45 minutes and one hour.

The Reviewers in the PDR Process

There has been much discussion within the NZ CPD Committee, other NZ committees and with the Medical Council of New Zealand about whether the Reviewers must be practising within the same medical speciality as the individuals they are reviewing. The NZ CPD Committee members and support staff have met with New Zealand Society of Dermatologists and the staff and Fellows of the Royal Australian & New Zealand College of Obstetrics and Gynaecologists; both groups having developed a successful practice review programme, but neither have the diversity of medical practice found within the Royal Australasian College of Physicians, so they were not able to provide guidance in this area. The NZ CPD Committee has grappled with this issue and while it may be possible for another internal medicine specialist to review a cardiologist, it may be appropriate for some specialists such as sexual health specialists, occupational and environmental physicians, and public health physicians to review only those participants within their craft group

During two PDR interviews a general physician and endocrinologist were also present. The other two specialists both practise in large public tertiary hospitals, in similar clinical settings; therefore, there was commonality between the participants’ clinical practice and service delivery structure. During the interview the two external Reviewers were able to add constructive commentary to the discussion e.g. “have you thought of doing that this way?”.

Feedback received from the pilot strongly indicates that at least two Reviewers are necessary to provide a balanced process; additionally it was noted that the participants gained more having two Reviewers present in the interview. (Eight participants agreed or strongly agreed that two Reviewers were required.) The participants were united in their view that “one of the PDR Reviewers should be a Fellow practising in my speciality”; only one of the participants was neutral in this regard. Feedback indicated that the second Reviewer could be from another speciality or another person who was not a medical practitioner. One participant opined that the second Reviewer could be “from the hospital management” and made additional comments (as did two other participants) that management needs to be involved in the process in order to validate it. Another participant thought the process was less time consuming with two reviewers.

Implications: The feedback from the participants is that two Fellows from the same speciality do not have to be involved in the PDR process. Whilst there is consensus that one Reviewer has to be practising in the same speciality, the other Reviewer can be practising in another speciality or may not be a medically trained individual. There is the potential then for the PDR be used across various specialities, whereby a few individuals could be trained in the administration of PDRs and then they could undertake the PDR with the relevant Clinical Director / Clinical head of department. An additional benefit would be that the various

specialities, within a larger hospital, could gain insights into processes undertaken by other departments through being involved in the PDR process.

The Medical Council of NZ's policy states that: "the RPR must include some component of external assessment; that is, by peers external to the doctor's usual practice setting¹⁰".

It is not clear if a physician practising in another department of a hospital would be deemed external to the doctor's usual practice setting.

The Structure of the PDR

The PDR Tool covers a number of components e.g. clinical activities, peer review and cultural competency. The NZ CPD Committee sought clarification regarding the information flow of the Tool and if some re-ordering of the material was required. Most participants supported the PDR's structure noting it is "fairly logical" with one participant suggesting that some re-ordering was required whereby section 1 (overview of the year) was moved so it was near the end of the process.

The pilot did identify that some additional information was required prior to the PDR interview occurring. Five participants thought a "Completing your PDR" document would be useful as not all Fellows would be familiar with this type of exercise. One participant stated "I think [it] would help our thought processes and planning".

When asked to identify those sections of the PDR that required further explanation, two participants wanted more information relating to clinical audit and research section. Two participants also wanted more information about relating their objectives to credentialing, service requirements and clinical responsibilities.

Six participants thought an FAQ factsheet would be useful.

Recommendations:

In order to understand the entire Regular Practice Review framework and how the PDR contributes to this exercise, an FAQ fact sheet is being developed and provides a very brief introduction to the Regular Practice Review process. The participants thought the process was not complex, as they had been well briefed by the Clinical Director, but an FAQ document might make the process easier to follow.

The Content of the PDR

This pilot is the first stage of an ongoing PDR process; therefore the participants were unable to comment on all the components of the PDR.

Participants were asked if there were any additions to be included in a future PDR. Only one participant made suggestions for further inclusions; "including more data on case-mix being seen – perhaps slightly more overlap with credentialing process".

One of the chief reasons for implementing a PDR is to improve physicians' practice:

¹⁰ The Medical Council of New Zealand. 2011. *Policy on Regular Practice Reviews*, 2011. Accessed November 2013 from: <http://www.mcnz.org.nz/assets/Policies/Policy-on-regular-practice-review.pdf>

“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 receive¹¹”.

Participants were asked to identify those sections of the PDR that would make the biggest contribution to improving their practice.

Seven participants stated that the PDR section focusing on clinical activities e.g. maintaining clinical skills, clinical competence and cultural competence was the section that made the greatest contribution to practice improvement. The section on job satisfaction was also noted by six participants to be important in improving practice.

Overall, the participants affirmed that the PDR process has the potential to improve their practice. Participants mentioned that is a useful exercise to review and reflect upon their practice and their professional activities: specifically the PDR assisted them in identifying areas for improvement and planning. The participants also saw the benefits of the PDR in planning CME goals and assisting with other activities outside work, such as academic activities.

- “Highlights both strengths and deficiencies and allows a frank discussion of potential solutions”
- “Focuses on potential issues and also gives a chance to have a two-way discussion about other issueswhich may be difficult to broach in other less formal situations”
- “Makes one feel supported”
- “We often seem to be working individually but this process mandates group discussions and it improves collegiality”
- “A good way of reviewing practice over a period of time and forces one to reflect on one’s work”.

There were some additional comments made:

1. Two participants voiced concerns about how the PDR might be used; “Fear it (sic) that management could use this tool inappropriately when it suits that group”.
2. Three participants expressed the opinion that if the PDR Tool raises issues then these need to be followed up by management. There appears to be an underlying theme that management has to embrace this process otherwise there is little potential for change.
 - “If issues identified are not then addressed by management then it is of no benefit to the clinician.”

The Medical Council of New Zealand describes the Practice Review Process as a formative process: “The RPR is a formative process. It is a supportive and collegial review of a doctor’s practice by peers, in a doctor’s usual practice setting¹²”.

In developing the RACP’s framework, it was important that these principles were adhered to in order to gain Fellows’ acceptance. Many Fellows¹³ hold the view that the Regular Practice

¹¹ Ibid.

¹² Ibid.

¹³ The members of other NZ committees have raised these issues with the Chair, NZ CPD Committee.

Review is an assessment or competence-based pass / fail tool, i.e. that is a summative process.

The majority of the participants reaffirmed the Committee's perception that the PDR is a formative process. One participant thought it was summative process and another thought it had summative and formative components. One participant commented:

"The PDR seemed far more constructive and self-directed than something coming from the outside and setting limits or mandatory goals".

Implications:

The participants generally found that the PDR was helpful in improving their practice and this feedback is similar to that reported in the recent pilot undertaken by the Royal New Zealand College of General Practitioners¹⁴.

It was useful that participants were able to identify those sessions of the PDR that were most useful in improving their practice. The NZ CPD Committee may be able to further refine / define these components. It will also be helpful when designing supporting materials to encourage Reviewees to firstly focus on these areas of their PDR.

Most participants also noted that the process was formative and should allay the fears, held by some, that the PDR is summative process where individuals are assessed.

Issues Relating to Confidential Information and the PDR

The question of who should have access to the Regular Practice Review data (including the individual PDR) remains a vexing issue. The Health Practitioners Competence Assurance Act 2003 (the HPCAA section 34 (1) reads:

If a health practitioner (health practitioner A) has reason to believe that another health practitioner (health practitioner B) may pose a risk of harm to the public by practising below the required standard of competence, health practitioner A may give the Registrar of the authority that health practitioner B is registered with written notice of the reasons on which that belief is based.

This section of the HPCAA raises the issue that competence and fitness to practice issues could potentially come to the Reviewers' attention. If the completed PDRs were returned to the RACP then it may be possible that the RACP is placed in the position of reporting the Reviewee to the regulators and health organisations. RACP does not see this reporting function as part of its role and to this end the NZ CPD Committee has maintained that the PDR (and the Service Review) remains with the Reviewee's work place and the employer¹⁵.

Participants were asked to give their views regarding who should retain the PDR information. Six of the participants thought that the PDR must remain confidential to the work place. One participant noted that a confidential interaction "allows more frank and open discussion" to occur. It can be concluded from this observation that allowing others outside to view the PDR may reduce the potential for the PDR to improve practice. Three participants held different views: "possibility selected components could be made available to other parties" or

¹⁴ Data presented at the MCNZ's VEAP meeting 20 September 2013

¹⁵ NZ CPD Committee Minutes 28 February 2012

the RACP should/perhaps hold the PDR. Two participants thought it was up to the “Reviewee to disclose it if desired or needed” or “Individuals could be asked [if they wanted to disclose the PDR]”.

Implications:

The PDR has to remain with the work-place rather than being held by the RACP. Any competency concerns highlighted by the PDR process should be escalated by the Reviewee’s work place.

Any Additional Comments

The participants were asked to provide any further comments on any aspect of the PDR. The comments are collated into three categories:

1. Future of the PDR

“The PDR has to live beside service credentialing and this may be the challenge”.

“Not clear how it would benefit Fellows at risk and therefore targeting remediation. However when the process has been fully developed there will be multi-source feedback requirements with peers and patients”.

2. Management’s Support of the PDR Process

“It is essential that hospital management buy into the process”. There were another two comments of this nature, and this has implications for getting the PDR accepted within the hospital system. It may be necessary to work with Clinical Directors in a range of hospitals to gain acceptance of the process for vocationally registered doctors.

3. Positive feedback on the PDR experience

“Overall a fairly beneficial process”.

“The first experience was a positive one, I can see the potential for benefits, only in time will we know whether the process fulfils its purpose”.

Middlemore Hospital’s Experience with PDRs

The current PDR developed by the NZ CPD Committee is based upon a document developed by Dr Carl Eagleton, a former NZ CPD Committee member. Dr Eagleton has conducted 20 PDR interviews with general physicians at Middlemore Hospital in Auckland. Dr Eagleton’s view is that a PDR does not need to be completed every year. The Medical Council of New Zealand has set the threshold that a generally registered doctor must complete a practice review every three years.

Feedback from Middlemore Hospital also indicates that two individuals need to be present in the interview – the Director or Clinical Head and most likely the Service Manager to give some robustness to any concerns raised in the interview. Two people provide a different perspective and assist with the implementation of the PDR process. It is not really necessary to have an individual practising in the same medical speciality as a Reviewer; however, if the Reviewee was practising in a unique sub-speciality this may change the Reviewer mix.

In Dr Eagleton's experience, the PDR process does not require a highly detailed introductory document: half a page outlining "Why we are undertaking a PDR process" would be sufficient and developing FAQs would be more beneficial in answering participants' queries.

Dr Eagleton is considering making adjustments to the PDR: removing section 3.2 (Clinical pathway development) as it overlaps with section 4 (key accountabilities). Section 4 generates the most questions from the Reviewees, especially in relation to clinical plans and linking these to the Reviewee's objectives.

Dr Eagleton also thought more information might be required regarding Multi-source Feedback (MSF), and all Reviewees should be encouraged to complete a MSF before they attended a PDR interview.

Dr Eagleton also suggested that an additional section could be added to the PDR to provide further context regarding the individual's role:

List two things you want to:

- a. Stop doing in your role
- b. Start doing in your role
- c. Stay doing in your role

The PDR process at Middlemore Hospital had been generally seen as a positive experience, but it was viewed by Reviewees to be quite labour intensive.

The Service Review

The Regular Practice Review programme developed by the RACP has an additional component whereby the individual PDRs are studied in context with a Service Review. Examining the individuals and their practise without recourse to the health service they are practising within may not provide a complete picture of the challenges faced or the potential developments available to the individual.

In early April 2013, three clinicians, who were members of the NZ CPD Committee, travelled to North Shore Hospital to undertake a Service Review with the Director of Cardiology and Service Manager of Cardiology.

The three external Reviewers examined each component of the Service Review, and discussed the completed Service Review with the Director and the Service Manager. Although the three external Reviewers practise in different medical specialities (general medicine, endocrinology and rheumatology), they were able to provide feedback regarding the Service Review, especially in relation to the peer review activities undertaken at North Shore Hospital.

The Director and external reviewers were asked via a short questionnaire to provide feedback on the Service Review component.

This section of the report summarises the feedback from four clinicians – the three Service Reviewers and the Director - referred to as the "Service Review clinicians".

The Service Review clinicians agreed that at least two reviewers are required during a Service Review; however, they held differing views as to whether it was necessary for the

Service Reviewers to be practising in the same medical speciality as the service / department being reviewed.

One clinician stated: “By and large, I think it is valuable to have different perspectives on the service. The components of the service review are independent of the subspecialty. There is some potential benefit in having a reviewer from the same speciality in that it may provide some speciality-specific perspectives on service structure – but this is not fundamental to the process”.

Another clinician thought it was not the content of the service function that was important but the relationships amongst the people in the PDR that needed to be studied to see how they are working together. With this in mind it is not so important that the Reviewers come from the same medical speciality.

The Service Review clinicians were in agreement that external reviewers are essential, not only to meet regulatory requirements, but they add value by ensuring there is objectivity, independence from the organisation and they bring a different perspective to the issues raised within a Service Review discussion.

The Service Review, that at the pilot site took longer than an individual PDR, lasted 90 minutes. The Service Review clinicians thought this was a reasonable amount of time given the information to consider, the number of areas that had to be focused upon and then time to provide constructive feedback.

The issue has been raised by the NZ CPD Committee that the individuals reviewing the Service Review may require training. Feedback from the Service Review clinicians indicates that some training is required to understand:

1. Background of the Service Review (e.g. how it fits with the entire Regular Practice Review process)
2. What is to be achieved by undertaking a Service Review
3. “Some training in the process and in general HR and service structure and principles would be valuable”
4. “Need to have some degree of uniformity in the process as it is not entirely intuitive”.

One clinician was unsure about the need for training as he thought “rigid criteria may exclude valuable insights and lines of inquiry”.

The objective of the Service Review is to provide an overview or macro view of the entire service. There are nine components of the Service Review that need to be maintained on a regular basis. One Service Review clinician was not sure that this objective could be achieved: “...there will be difficulties in finding reviewers to conduct the service review due to their own time constraints and work pressures. The Service Review interviews may not be too time-consuming, but coordination of the whole review will be”.

The Service Review clinicians concurred that implementing a Service Review in their department would change the way they did things and they all found attending the Service Review pilot a valuable experience. General comments are listed below:

- “I enjoy knowing what motivates my colleagues and how they accomplish their goals.”

- "Similar to credentialing process."
- "I would want to receive education and guidance on the review content, processes and expectations so I could be adequately prepared for it"
- "Strongly overlaps with credentialing, performance review process and all these things could be bought together by having a common or several College reviews at one time when the services are being reviewed / credentialed. Could have a College observer."

Appendix One: The Professional Development Review

Appendix Two: The Service Review

Appendix Three: Medical Council of New Zealand's Policy on Regular Practice Review