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Regular Practice Review Trials Process, Guidelines and Forms

FOREWORD

The Royal Australasian College of Physicians (RACP) is committed to developing evidence-based approaches to professional development that achieve quality improvement. As part of this commitment, the RACP New Zealand CPD Committee has developed a Regular Practice Review (RPR) framework. 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.

Development of the framework has also been guided by The Medical Council of New Zealand's (MCNZ) policy on RPR. The MCNZ wants 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 The MCNZ has encouraged medical colleges to develop Regular Practice Review (RPR) processes for doctors registered in a vocational scope of practice.

RACP is continuing RPR pilots in a tertiary hospital, a secondary hospital and a hospice and is beginning pilots at new sites in 2016. RACP strongly encourages Fellows to participate in RPR as part of their CPD programme and in particular encourages Fellows to participate in trials of the RPR framework so that the College can assess its impact, and adjust it to ensure it is meeting their needs.

Dr Tony Scott
Chair
Practice Review Support Working Group

Project Support

[Learning Support Unit](#)

Office of the Dean

¹ <https://www.mcnz.org.nz/assets/Policies/Policy-on-regular-practice-review.pdf>

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1. OVERVIEW

1.1 Purpose

Regular Practice Review (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 that is presented in ways most likely to be effective in improving performance
- personal professional development and workplace improvement, both aimed at improving health care outcomes
- early identification of underperformance
- early identification of the risk of underperformance

One aspect of RPR that sets it apart from other reviews is the focus on the needs of the individual doctor. The focus on self-care and on the candidate's health and on identifying ways in which the organisation either supports or hinders the doctor in their work and in their development cements RPR as a developmental tool designed to assist individuals improve their practice in the context of the organisation they work in.

A key outcome of an RPR is an individual clinician'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 RPR survey tools.

1.2 Principles ²

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

² Amended from <https://www.mcnz.org.nz/assets/Policies/Policy-on-regular-practice-review.pdf>

- 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
- provides constructive feedback to the doctor being assessed

1.3 Background and structure of the RACP regular practice review³

The RACP New Zealand CPD Committee has been developing an RPR framework since 2010. In developing the framework, it consulted with a number of other medical colleges, associations and societies. RACP has conducted RPR pilots in a tertiary hospital, a secondary hospital and a hospice. Members from RACP's Divisions, Chapters, Faculties and the Māori Health Committee have also contributed to the development of the materials. The resulting RPR framework is recommended to RACP fellows participating in the RACP CPD program.

The framework has two interlocking parts that comprehensively review individuals and the service / practice they work in. Each RPR consists of both an annual 'professional development review' (PDR) of each RACP fellow within that service or department (the candidate/s) and an overarching 'Service Development Survey' (SDS) that will occur every three years.

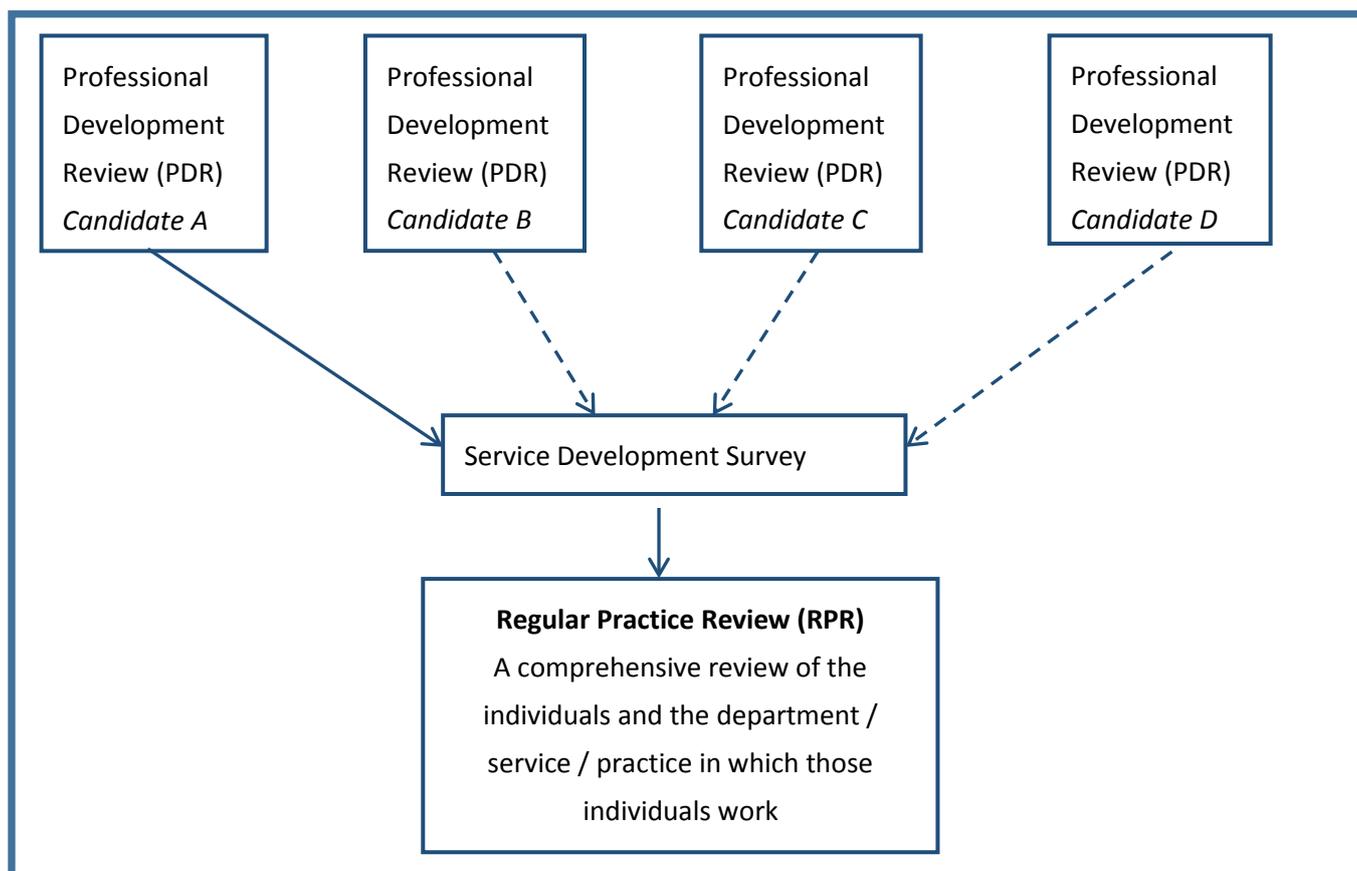
The first phase of the RPR involves the candidate/s in a service or department completing a PDR form. Each candidate will send the completed form to two nominated reviewers and organise to meet with them to discuss it (see section 2.5.1 for details on recommended PDR reviewers). The PDR includes peer 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 then inform the SDS.

The SDS outlines the key elements of the health services provided. For example, section one of the SDS asks the service to identify any particular peer review groups managed by that service. 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.

³ Adapted from the Report on Regular Practice Review Pilot 2013 prepared by Rosemary Matthews. Senior Executive Officer, New Zealand Office. Dec 2013.

Diagram 1. The two components of Regular Practice Review



The New Zealand CPD Committee believes:

1. That it is critical to examine not only how an individual is functioning within their work place/s, but that a whole systems approach must be adopted if health services are to be delivered at an optimal level.
2. That RPR should be implemented within current work places with minimal disruption to the doctor's clinical practice.

The RPR cycle occurs over three years with an individual completing PDR tasks in each of those three years. The SDS occurs once every three years.

1.4 Physicians in sole practice

For Physicians working in sole practice a hybrid form that combines key elements of the PDR and SDS has been developed and is currently subject to trial. Please contact the [RACP Learning Support Unit](#) for further information.

1.5 Physicians working in more than one service

Where physicians are working across two or more health services or in a combination of private practice and public health it is important that confidentiality of information (for the individual and the services) is maintained. It is also important that requirements on physicians are not duplicated or onerous. This may necessitate conversations between the candidate and the services they work for to identify an approach to RPR that is likely to result in the most valuable feedback to the candidate.

1.6 Trials of RPR

Trials of the RACP framework for RPR began in 2013 and are continuing. Feedback from trial participants so far indicates that the process is a positive one and that both the PDR and the SDS contribute to practice improvement. [A report of the first stage of this trial at North Shore Hospital](#) Auckland is available online.⁴

1.7 Confidentiality and the information provided in RPR

The review is designed as a development document for the candidates and for the health service that employs them. RACP does not see nor retain copies of PDRs.

The review also provides information that is vital to employers being able to assure the quality of their staff. Some information gathered from PDRs (clearly indicated) and the information gathered for the SDS may be made available to health service administrations. In some cases this may be used for credentialing or other compliance processes.

The PDR process could be deemed a Quality Assurance Activity (QAA) under section 52 of the Health Practitioners Competence Assurance Act 2003. The candidate, or where applicable their employer, may apply for the PDR to be recognised as a protected QAA (PQAA) under section 53 of the Act. The only exceptions to this are where the reviewer assesses that the candidate “may pose a risk of harm to the public by practising below the required standard of competence” (section 34), or where the Minister of Health authorises release of information where it relates “to conduct (whenever occurring) that constitutes or may constitute a serious offence” (section 61).

Disputes may occur about the conduct of PDRs, including about access to and use of information, or about reviewer arrangements. Disputes can be referred to the NZ CPD Committee for advice however RPR is designed as a local practice improvement program and where possible disputes should be managed at the local level.

⁴ <https://www.racp.edu.au/docs/default-source/default-document-library/131202---practice-review---report-on-regular-practice-review-pilot.pdf?sfvrsn=0>

2. PROCESS

The RPR cycle is designed as an ongoing quality improvement framework. Each individual physician completes the PDR form and has a PDR interview each year. The Service Development Survey occurs once every three years.

2.1 Enrolling in an RPR.

Individual candidates (ie. the individual physicians participating in RPR) and or health service units can [download the materials](#) they will need to complete an RPR at any time. Where a health service is intending to participate in RPR it is important the clinical director of the unit has discussed the process with all staff impacted. It is important that participants know who will have access to the information and whether that information will be used for other processes such as credentialing.

2.2 Pre-participation administration and set-up

A key step in the preparation phase is to identify who will act as reviewers for the PDRs and for the SDS. More information on reviewers is in section 2.5.

2.3 Completing a professional development review (PDR)

A PDR is an annual formative review of the candidate's practice including clinical, professional skills, job satisfaction and job sizing. The PDR is a continuous quality improvement process and its objectives are to:

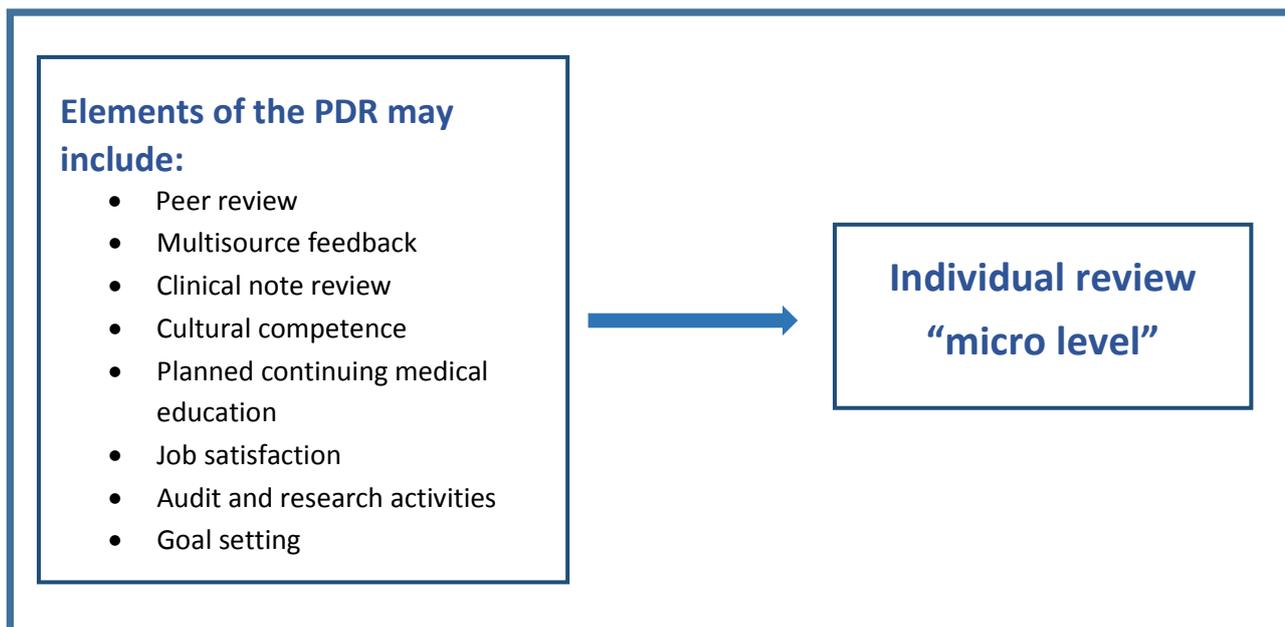
1. define and clarify performance expectations particularly as expressed in the position description
2. review performance against previous objectives
3. plan performance objectives over the next 12 months
4. review feedback from PDR forms (eg. audits / MSF) and identify areas of development
5. review and plan CME/CPD activities relevant to scope of practice and learning needs identified

There are two steps and several elements of the PDR process:

Step 1: Completing the PDR form.

Step 2: An interview with two doctors, ideally one internal and one external to the candidate's practice.
Providing an external review may not be possible for all of the reviews in a particular location.

Diagram 2: Elements of the professional development review



Not all these elements of a PDR need to be completed in one year. For example, peer review could be identified in year one as a future activity. In year two a candidate may complete a peer review and discuss it in their subsequent PDR interview. The interview might lead to planning further components, such as multisource feedback or education, which are then completed. Over three years, all these activities are designed to contribute to a composite overview of practice.

2.3.1 Step 1. Completing the PDR form

The [PDR form](#) can be downloaded from the RACP RPR webpage. There are six sections in the PDR form addressing overall practice and the candidate is responsible for completing all sections. In some sections candidates will also need administrative assistance to provide details of service/leave etc. but the candidate is responsible for all information in the PDR. Sections where information may be shared with health services are highlighted in yellow.

- Section One: **Overview of the year.** What progress has been made against previous objectives?
- Section Two: **Areas of speciality practice.** Is the job size current and relevant? What peer review activities have been undertaken during the review period?
- Section Three: **Non-core or non-clinical activities.** A portfolio of the candidate’s activities undertaken with special reference to auditing their medical practice.
- Section Four: **Professional development and planning.** A focus on future CME / CPD plans for the next 12 months.
- Section Five: **Job satisfaction.** Information on job satisfaction.
- Section Six: **Maintaining your health.** Information pertaining to the candidate’s own health.

A copy of the form can be found in part two of this manual. Completing the PDR takes between 1 and 2 hours depending on the number of peer review activities included, and depending on what issues the physician wants to bring to the interview.

2.3.2 Step 2. The PDR interview

Each candidate will meet with a physician practising within their speciality and another person who may or may not be a physician (see section 2.5 for more detail on reviewers) to discuss the information they have entered into their PDR. In some cases it will be advantageous and/or practical for one of the reviewers to be the candidate's line manager. If this is the case this must be agreed by the candidate.

The candidate will email a copy of their completed form to the reviewers at least three days prior to the interview. The candidate will bring to the discussion a copy of their completed PDR form and any supporting evidence/materials they wish to discuss. In particular this may include reports of peer review activities undertaken.

A key component of the conversation will be agreement of the professional/personal development plan in section four of the PDR form. This will include agreement on appropriate peer review activities to complete before the next PDR.

PDR interviews are conducted in an informal interview setting. Meetings are on average 45 - 60 minutes long and this is mostly dependant on the issues brought to the discussion by the candidate.

2.3.3 Peer Review Elements of the PDR

*"Peer review is an evaluation of the performance of individuals or groups of doctors by members of the same profession or team. It may be formal or informal and can include any time when doctors are learning about their practice with colleagues. Peer review can also occur in multidisciplinary teams when team members, including other health professionals, give feedback. ... Peer review normally includes feedback, guidance and critique of your performance."*⁵

Peer review is an integral part of any PDR. Like all quality assurance, these peer activities should be fit for purpose. The following are examples of peer review activities that might be undertaken as part of a PDR. The activities to be included in the next PDR will be discussed between candidate and reviewers.

- Clinical Notes Review
- Disease Review
- Procedure Review

⁵ The Medical Council of New Zealand's [Recertification and Continuing Professional Development Booklet](#) (2015), p. 5.

- Consultation Review
- Personal Learning Project
- 360° Review of Practice / Multi-Source Feedback (MSF).

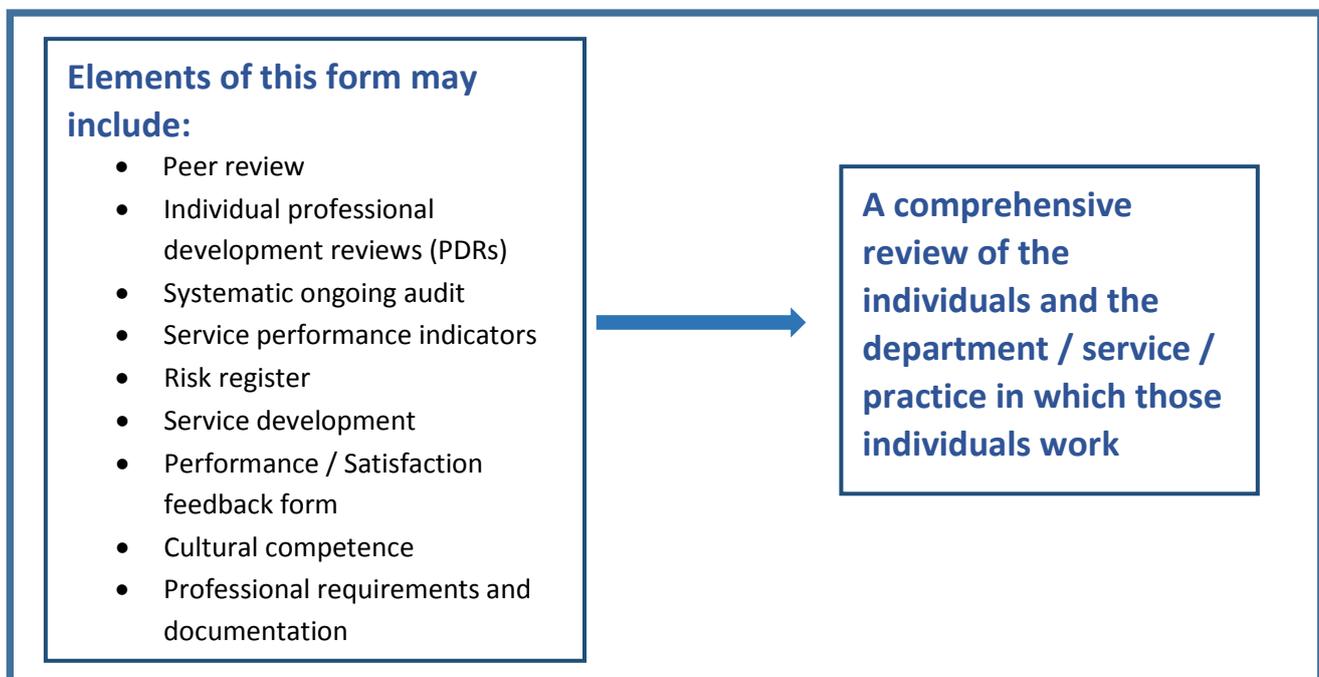
2.4 Completing a Service Development Survey (SDS)

The SDS is an over-arching review of the service and of the candidate/s who work in that service. The SDS is designed to:

- provide an overview or macro view of the entire service
- complete the picture of the challenges faced by, and the potential developments available to, the individual candidate/s
- provide rich information about the context in which staff practise, to assist candidates and management to focus upon the key elements of service delivery.

The SDS is designed to occur every three years. The SDS can be applied to a single service, a department or an entire hospital. It provides insight into the health care delivery across the service, the infrastructure that supports it and the physicians who work there.

Diagram 3. The Service Development Survey



Once the PDR interview/s have occurred, the service/clinical leadership complete the SDS form.⁶ This is reviewed by two or three experienced physicians who then meet with the service/clinical leaders to review each element and draft a report of their findings. The SDS interview will take approximately 90 minutes.

There are nine elements in the Service Development Survey (see diagram 3). The initial review examines the level to which a service is meeting these elements and identifies those to be maintained on a regular basis (eg, annually). Any potential gaps in the Service Development Survey will need to be addressed and will form part of the service's plan for strategic development.

The SDS should be seen as a central element of both the unit's continuous quality improvement program and the quality improvement program of each individual within that unit. Once a baseline is established with the first SDS future reviews should be benchmarked against the baseline and against the SDS outcomes for other similar unit/services

2.5 Appointment of reviewers for the PDR and the SDS.

2.5.1 Reviewers for the PDR

Each candidate will have a PDR interview with two reviewers:

1. At least one reviewer must be a physician from the same speciality as the candidate. The second reviewer could be from another speciality and may not be a physician (eg. it may be appropriate for a hospital/workplace manager/ practice manager to be the second reviewer).
2. One reviewer can be from the same service/unit as the candidate and where possible one of the reviewers will ideally be external to the doctor's usual practice setting (for example a physician from another service, or they may be from another unit in the same health service if it is large and diverse).
3. In some cases it will be advantageous and/or practical for one of the reviewers to be the candidate's line manager. If this is the case this must be agreed by the candidate.

Ideally reviewers should be chosen in consultation between the candidate and their manager. A number of factors may influence this choice including the availability and location of reviewers, whether a reviewer is available to complete a number of reviews for a larger unit, the working relationship between candidate and line manager.

⁶ A form that combines aspects of the PDR and SDS forms is being developed to meet the needs of physicians working in sole practice.

2.5.2 Reviewers for the SDS

At least two reviewers are required to complete the SDS. Both SDS reviewers must be external to the service to ensure objectivity and independence from the organisation being reviewed.

While there may be benefit in having a reviewer from the same speciality it is not fundamental to the process as the components of the SDS are independent of speciality. While it is important for one reviewer to be a physician it may be appropriate for a second reviewer to be non-medical (eg. a hospital administrator / practice manager).

Reviewers completing an SDS will be required to undergo preparation on the role that will cover:

- 1) Background of the SDS (eg. how it fits with the entire RPR process).
- 2) What is to be achieved by undertaking an SDS.
- 3) Strategies for ensuring uniformity of implementation of the SDS process.

2.6 RPR and CPD / Peer Review Requirements

Participation in RPR related activities includes:

1. completing the PDR form
2. completing related activities such as peer review
3. meeting with your reviewers for the PDR discussion
4. completing a personal performance plan based on the outcomes.

The time candidates spend on RPR can contribute towards the MCNZ annual CPD requirement of 10 hours peer review.

Participation in RPR can be claimed in MyCPD under Category 5 'Practice Review & Appraisal' at 3 credits per hour for 2016 and in Category 1 'Practice Review and Improvement' for 2017.

2.7 Evaluation

All participants will be asked to provide feedback on the value and conduct of the RPR process. Feedback will be anonymous, provided to the RACP and used to improve the process. The feedback sought will include questions that will allow the RACP to measure both the impact of RPR on practice and the time and resources involved in the process.

Feedback will be collected longitudinally to establish the level of change achieved through RPR over time. It will be collected:

1. From candidates before participating.
2. From candidates and reviewers after the PDR interview.
3. From heads of departments/reviewers after the SDS interview.

3. FREQUENTLY ASKED QUESTIONS AND FORMS

Frequently asked questions

1. What is a Professional Development Review (PDR)?

A PDR is a formative review of the individual doctor's practice including clinical, professional skills, job satisfaction and job sizing. It is undertaken as an interview with two reviewers, one internal and ideally one external to the hospital department. PDRs provide an opportunity for individual doctors to: define and clarify performance expectations; plan and review performance objectives; seek feedback from other health professionals; and examine Continuing Professional Development activities. The latest version of the PDR is available to download from [RACP's CPD regular practice review webpage](#). Some information provided in the PDR may be made available to the health service employing the individual as part of its quality assurance processes. Candidates will be made aware if this is to happen.

2. What is a Service Development Survey?

A Service Development Survey is an over-arching review of the service or department in which the doctors, who have completed the Professional Development Review, are practising. The Service Development Survey outlines in broad terms the key elements of health delivery for a particular service, a department or an entire hospital. It will provide insight into the health care delivery across a service area and the infrastructure that supports it and the doctors involved. The latest version of the Service Development Survey is available to download from [RACP's CPD regular practice review webpage](#). Much of the information in the SDS will be made available to the Health Service. Where possible this information will be used to meet the needs of other compliance processes such as credentialing.

3. What is a Regular Practice Review (RPR)?

The MCNZ requires that all doctors registered in a general scope participate in a regular practice review (RPR) on a regular basis, once every three years. The MCNZ expects that doctors registered in a vocational scope will also start to engage in a RPR activity. The RACP framework is recommended for physicians participating in the RACP's CPD program. The RACP RPR is designed to be a continuous quality improvement process.

The MCNZ has identified several key principles relating to RPR, including:

- "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 setting.

- RPR is informed by a portfolio of information provided by the doctor, which may include audit outcomes and logbooks.
- Multi source assessment forms part of a RPR.
- The RPR must include some component of external assessment that is by peers external to the doctor's usual practice setting".⁷

RACP strongly encourages its Fellows to participate in an RPR as part of an accredited CPD programme. The 2013 RPR pilot indicated it can be a supportive and useful exercise for individuals to address particular areas within their professional development plan. RACP has developed forms to support the two aspects of the RPR.

- a. Professional Development Review (PDR). The latest version of the PDR is available on [RACP's CPD regular practice review webpage](#).
- b. Service Development Survey. The latest version of the Service Development Survey is available on the [RACP's CPD regular practice review webpage](#).

4. I'm a sole practitioner – is the RPR process the same for me?

Fundamentally the process is the same however there will be one RPR form that covers both the PDR and the SDS aspects of the review which is currently under development. This form has recently been developed and is under trial. Please contact the [RACP Learning Support Unit](#) for further information.

5. Why is the RACP rolling out this process?

The RPR process aims to improve quality outcomes for the organisation and the doctor while meeting MCNZ's requirements. By implementing an RPR, it is anticipated there will be improved effectiveness and efficiency within the health system and, ultimately, better patient outcomes. The College is exploring the potential for the process to reduce the compliance burden for physicians and for heads of department.

6. How does SPPP help with my PDR?

RACP developed the Supporting Physicians' Professionalism and Performance (SPPP) framework to support members to identify and exceed high standards of performance, and to "understand our practice and guide our performance development. It will also assist with understanding clinical practice and demonstrating our professionalism to patients, colleagues and organisations" during a PDR.

⁷ Medical Council of New Zealand's Policy on Regular Practice Reviews.

7. How will I know that I have been selected for a practice review?

It is likely the entire service will be participating in a Service Development Survey and all physicians in the service will be invited to participate in a PDR.

The service or department's clinical director or manager will give several weeks' notice that the PDR interviews will occur, discuss the process and provide the PDR form (available on the CPD regular practice review page), to the candidates to complete.

8. Is any part of the RPR mandatory?

Yes, the MCNZ requires that all doctors registered in a general scope participate in a regular practice review (RPR) on a regular basis, once every three years. The MCNZ expects that doctors registered in a vocational scope will also start to engage in a RPR activity. RACP strongly encourages its members to participate in a RPR as part of CPD.

9. Who will administer the PDR?

The Professional Development Review (PDR) is intended to be used as an annual review form to enhance a doctor's performance. It is self-completed and then reviewed by the candidate and two others.

10. What resources are needed to undertake a PDR?

The completed [PDR](#), two reviewers, and an interview room.

11. Is Multi-source Feedback involved?

MCNZ has indicated that RPR must include "multisource assessment and a component of external assessment". Multisource feedback (MSF) provides such assessment and RACP encourages fellows to participate in a MSF. The College is currently running a trial of multisource feedback and would welcome interest in participating in that trial. Please contact [RACP Learning Support Unit](#) for more information.

12. Do I have to pay to complete a PDR?

The PDR form is free to be used by any physician enrolled in RACP's MyCPD programme. In a clinical department, time associated with the PDR should be considered a routine non-clinical departmental activity (ie. similar to an annual review).

In private practice, time associated with the PDR is part of the physician's CPD time. Any associated expenses would need to be paid for by the candidate and could be claimed as a business expense.

13. What is the benefit to me in completing a PDR?

The PDR will encourage reflective practice. It will provide an opportunity to reflect upon the what, how and why of practice. The process contributes to maintaining professional standards, meeting MCNZ's requirements, and in some cases may contribute to organisational credentialing activities and annual physician appraisals.

14. Who will see the results of a PDR?

This depends on the information. Any aspects that may be shared beyond the candidate and reviewer will be identified before completion. All other information will remain private and confidential between the reviewers and candidate.

The PDR process could be deemed a Quality Assurance Activity (QAA) under section 52 of the (NZ) Health Practitioners Competence Assurance Act 2003. The candidate, or where applicable their employer, may apply for the PDR to be recognised as a protected QAA (PQAA) under section 53 of the Act. The only exceptions to this are where the reviewer assesses that the candidate "may pose a risk of harm to the public by practising below the required standard of competence" (section 34), or where the Minister of Health authorises release of information where it relates "to conduct (whenever occurring) that constitutes or may constitute a serious offence" (section 61).

15. How will RACP be notified a PDR has been completed?

The PDR has a section that may be uploaded as evidence in the candidate's MyCPD programme under Category 5 "Practice Review & Appraisal" in 2016 and in Category 1 'Practice Review and Improvement' for 2017. The form only records those involved in the PDR process (the candidate and the reviewers), the date and the location. This process ensures the PDR information remains private and confidential between the reviewers and candidate.

When you submit your CPD return you are prompted to tick a box asking if you have been the subject of a PDR. Please tick the box if you have completed a PDR.

16. How do I record a PDR in MyCPD?

Given the nature of the PDR process it is a “Peer Review” activity and can be claimed in MyCPD under Category 5 ‘Practice Review & Appraisal’ at 3 credits per hour for 2016 and in Category 1 ‘Practice Review and Improvement’ for 2017.

It also counts towards the MCNZ's CPD requirement for 10 hours per year of peer review.

17. How does the PDR process work? Will other physicians be visiting my practice for the day?

RACP's practice review process does not require absence from practice for the day. You are required to complete the PDR Form, which is then discussed in an interview with two reviewers.

The PDR process involves completing various activities e.g. undertaking a multi-source feedback activity, and recording the information in a structured PDR form. You are also asked to reflect upon and document your CPD activities, both clinical and non-clinical. You should provide a composite picture of your practice. Provide the completed PDR form to your reviewers two to three days before your PDR interview. This will allow them time to consider the information you have provided.

Your reviewers will work through the PDR form with you in an informal interview setting. Include in the discussion any issues of concern relating to your practice. Your reviewers will provide feedback on your performance based on the materials you have provided.

18. How long will the Professional Development Review (PDR) interview take?

Based on the information collected from the practice review pilot, PDR interviews are, on average, 45 to 60 minutes long. The duration is somewhat dependent upon the issues brought to the discussion by the candidate.

19. What documents do I need to bring to my PDR interview?

A completed PDR and any supporting evidence / materials you wish to discuss in the interview.

If the information provided is being or will be used for a performance review you should expect to be advised, and agree or not in advance, and be informed of any other information and evidence requirements.

20. What are the reviewers looking for in the PDR interview?

The Reviewers will be reviewing the candidate's practice including their participation in CPD / CME relevant to their scope of practice, and activities relating to peer review and audit of medical practice. The discussion will also focus upon accomplishments in the previous year and plans for the future. Reflections on clinical activities should include opportunities to acquire new skills in the role and consideration of clinical duties in regards to job size and service delivery.

Non-clinical activities such as research and teaching will also be discussed and integrated into a review of overall practice. The candidate will be expected to demonstrate they are maintaining their skills across both clinical and professional domains.

Remember, the PDR is not a summative assessment. The key objective is to identify strengths and also indicate areas for improvement.

21. Can I fail a PDR?

The outcome of a PDR is intended as a formative rather than a summative review – it does not have specific pass or fail criteria. It is possible, and indeed desirable, that a PDR highlights areas of practice that it may be useful for the candidate to review or develop over the course of the coming year.

22. I am not sure how a PDR fits in with the Service Development Survey (SDS). How do these two components of the Regular Practice Review differ?

The first phase of the Regular Practice Review is completing a PDR and then discussing its contents with the reviewers. The PDR includes peer review and audit of medical practice, which are MCNZ requirements, but it also collects much richer information allowing the reviewers to gain insights into candidates' current work commitments (both clinical and non-clinical), future aspirations and CPD activities.

The completed PDRs then inform the SDS. The SDS reviews key elements of the health services provided by a particular service and of the practitioners working for that service. It provides insight into the strengths and areas for improvement of health care delivery across a service and the infrastructure that supports it and the practice of the doctors in that service.



Professional Development Review

Name of Person Being Reviewed	Click here to enter text.
Names of Person(s) Reviewing	
Meeting Place	
Time & Date of Meeting	

Prior to your Professional Development Review meeting, please complete sections 1-6 below as part of your preparation. Send the completed document to your Reviewer(s) – and your Clinical Head or manager – two to three days prior to your interview. Please note that the information you provide in the sections shaded in yellow may be made available to hospital administration for management and credentialing purposes. You should be notified if this will be the case.

Please bring your CPD Certificate of Participation to your review.

For background on the PDR please refer to the [“RPR process, guidelines and forms”](#) document.

The Structure of the Professional Development Review

- Section One: Overview of the Year.** What progress have you made on your objectives? If you did not previously set any objectives then reflect upon your accomplishments during the review period.
- Section Two: Areas of Speciality Practice.** Reflect upon your activities and skills. Is your job size current and relevant? Record the peer review activities you have undertaken during the review period. Note any comments or areas you wish to discuss.
- Section Three: Non-core or Non-clinical Activities.** Record the activities you have undertaken with special reference to audit of medical practice.
- Section Four: Professional Development and Planning.** Note down your future CME / CPD plans for the next 12 months.
- Section Five: Job Satisfaction.** Comment on your job satisfaction
- Section Six: Maintaining Your Health.** Provide information pertaining to your own health.
- Section Seven: Feedback.**

If you have any additional items for the discussion in your interview please list them

If you are not in a clinical role, but one which entails case or file review, this is still a clinical service requiring clinical competence. Similarly if you are researching or teaching then your review must focus on those areas such as review of research ethics compliance or evidence –informed teaching



Please complete sections 1-6 below (boxes will expand as needed).

SECTION 1: OVERVIEW OF THE YEAR

1.1 Overview

The purpose of this section is to note **briefly** what you have accomplished over the review period, whether you set formal objectives or not. What has gone well for you and what has not gone so well?

i. Accomplishments – Reflect upon those things that have gone well and why.
ii. Some things that you could have done better or will do differently next time.

SECTION 2: AREA OF SPECIALITY PRACTICE

2:1 Speciality skills and activities

Does your current practice enable you to:
i. Maintain your relevant speciality skills
ii. Meet any relevant credentialing requirements



iii. Acquire new knowledge or skills.
iv. Satisfy your career aspirations.

2.2: Current practice/tasks

Note any comments on your duties as they relate to your job size or the service for the department.

Your duties may include for example, inpatient work, outpatient clinics, analysing population data, revising rehabilitation plans, providing expert advice on case files

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2.3 Competence / Peer Review:

Note: It is a mandatory requirement of the Medical Council of New Zealand (MCNZ) that medical practitioners practising in New Zealand participate annually in 10 hours of peer review. For further information please go to MCNZ's booklet on CPD: <https://www.mcnz.org.nz/assets/News-and-Publications/Booklets/Continuing-Professional-Development.pdf>

Attachment one details the appropriate activities to undertake in this section.

Suitable peer review activities would include:

- Clinical Notes Review
- Consultation Review (clinic or ward round)
- Personal Learning Project (PLP)
- Disease Review
- Procedure Review
- Multisource feedback exercise
- Critical Incident Review
- Preparation and presentation at a Mortality and Morbidity Review.



Provide details on the Peer Review activities you have undertaken.

2.4 Cultural Competency

You must be aware of cultural diversity and function effectively and respectfully when working with and treating people of all cultural backgrounds⁸.

You should have an understanding of the:

- a) Treaty of Waitangi with relevance to Māori health outcomes and;
- b) Māori concepts of health.

General cultural competence

- Having **awareness** of your own culture
- Acquiring **knowledge** including culture-specific differences and the wider health policy context
- Developing your **skills** to interact and communicate in a culturally respectful and empathic manner

The College has developed a [cultural competency reflective form](#) based on the Supporting Physician’s Professionalism and Performance (SPPP) framework. There is an additional resource [“Cultural Competence Activities within CPD”](#) that identifies those CPD activities that contribute towards cultural competence.

List any cultural competence CPD activities you have participated in.

2.5 CPD Certificate of Participation

CPD Certificate of Participation for last calendar year provided at interview (delete as relevant)

Yes	No
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⁸ Refer to Medical Council of New Zealand’s *Good Medical Practice* (2013).



SECTION 3: NON CORE ACTIVITIES OR NON CLINICAL CONTACT TIME

Note: It is a mandatory requirement of MCNZ that medical practitioners practising in New Zealand participate annually in an audit of medical practice. For further information, please go to MCNZ's website www.mcnz.org.nz.

Other options are:

- Review by patients or consumers or a client satisfaction review. In a non-clinical setting you may wish to get feedback on your communications skills. You may wish to reflect upon your assessment of patient files.
- A public health physician should ensure that their work is reviewed by a colleague before publication e.g. an audit of statistical data provided in the report. Activities could include a reviewing the proposed publication to ensure it is consistent with the current available evidence.

3.1 Audit of Medical Practice & Research – Estimated hours completed and planned

Overview of the Audit & Research Activities Undertaken	Estimated / Actual hours for activity	Timeline for completion
Planned Activities for Next Year		



3.2 Quality Documentation & Clinical Pathway Development – Estimated hours completed and planned

Overview of Quality Documentation & Clinical Pathway Development Activities Undertaken	Estimated / Actual hours for activity	Timeline for completion
<i>E.g. system reviews</i>		
Planned Activities for Next Year (Single Department Audit)		

3.3 Teaching – hours per week & hours per annum

Overview Teaching Undertaken	Estimated / Actual hours for activity
<i>E.g. undergraduate, postgraduate, other (nursing, GP, allied health)</i>	
Planned Activities for Next Year	



3.4 Organisational Responsibilities – hours per week & hours per annum

Overview of Activities	Estimated / Actual hours
Planned Activities for Next Year	

3.5 Activities External to the Organisation – hours per week & hours per annum

Overview of Activities	Estimated / Actual hours
<i>E.g.: Professional Societies, Ministry of Health, NGOs</i>	
Planned Activities for Next Year	



SECTION 4: PROFESSIONAL DEVELOPMENT PLANNING

4.1 Planned CME / CPD for the coming year & sabbatical plans

Course/Conference/Activity	Focus/Topic/Learning	Timeframe

4.2 Intermediate and long-term Professional Development Plan (PDP)

Goal	Strategy	Timeframe / Progress



SECTION 5: JOB SATISFACTION

Think about your current role and provide information on the following:

5.1 How would you rate your overall job satisfaction?

(Place an x in the box that aligns with your response)

Very satisfied	
Satisfied	
Neither satisfied or unsatisfied	
Unsatisfied	
Very unsatisfied	

5.2 How could it be improved for you?

5.3 Future Planning

Under each of the three headings below, list two things that you would like to address in the future:

a. I would like to stop doing....
b. I would like to start doing....
c. I would like to continue doing....



SECTION 6: MAINTAINING YOUR HEALTH

6.1 Are you registered with an independent GP?

6.2 Are you
i. Following standard precautions and infection control practices
ii. Undergoing appropriate screening
iii. Being immunised against common serious communicable diseases where vaccines are available

SECTION 7: CLINICAL HEAD OR DIRECT MANAGER'S FEEDBACK ON YOUR PERFORMANCE

a. Clinical head or direct manager to summarise performance feedback

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7.2 Discussion of 360° feedback if completed

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Final sign-off on completion of process	
Reviewer(s)	Candidate
Date	Date

Signatures	Signature
Add electronic signature or print and sign	Add electronic signature or print and sign



ATTACHMENT ONE – EXAMPLES OF PEER REVIEW

An evaluation of the performance of individuals or groups of doctors by members of the same profession or team. It may be formal or informal and can include any time when doctors are learning about their practice with colleagues. Peer review can also occur in multidisciplinary teams when team members, including other health professionals, give feedback. In formal peer review, peer(s) systematically review aspects of your work, eg. the first six cases seen, or a presentation on a given topic. Peer review normally includes feedback, guidance and critique of your performance⁹.

1. Clinical Notes Review

A planned review of your clinical practice by reviewing a minimum of 12 randomly-selected or sequential case notes. Items to consider are legibility of record keeping (written or in a letter), evidence of effective communication (to patient and GP), presence of a treatment plan (including options if first line plan fails), follow up arrangements, appropriateness of treatment, consideration of differential diagnosis.

It is best to decide beforehand which aspect of practice will be reviewed. A record of both good and poor performance should be kept (e.g. evidence of giving patient an information leaflet, no letter written to GP, etc).

2. Disease Review

A systematic review of your management of a single disease (e.g. atopic eczema, acne, bcc, etc.). Select 6-12 recent cases and critically review your management, treatment plan, and appropriateness of treatment using case notes (i.e. a mini-audit). A comprehensive review of your use of / management of patients on a particular medication (e.g. azathioprine) would also qualify for this category. Decide beforehand which aspect of the disease management will be reviewed. A record of both good and poor performance should be kept.

3. Procedure Review

A systematic review of your performance of a single procedure (e.g. bronchoscopy, gastroscopy, tunnel line insertion etc.). Select 6-12 recent cases and critically review your performance, e.g. consent, technique, outcome, follow-up of results, using case notes (i.e. a mini-audit). A record of both good and poor performance should be kept.

4. Consultation Review

In a consultation review, a colleague sits in your clinic (2-3 hours) or alternatively accompanies you on a ward round observing your practice, giving feedback and critiques your practice. A minimum of four patients should be seen, preferably more than six. Decide which aspect of

⁹ Peer Review as defined in the Medical Council of New Zealand's *Recertification and Continuing Professional Development* (2013), p. 7. Available from: [MCNZ's webpage on recertification and audit](#).



the consultation you will concentrate on e.g. consultation style, examination technique, communication skills, treatment plan.

It is important to allow sufficient time between cases to allow appropriate feedback. Patients must be forewarned and have given their consent. A record of both good and poor performance should be kept.

5. Personal Learning Project

Personal Learning Projects (PLPs) are self-initiated learning activities that are planned then developed individually to address a question, issue or need relevant to professional practice. PLPs were first developed by the Royal College of Physicians and Surgeons of Canada. Many questions will naturally focus on expanding clinical knowledge.

PLPs are a flexible and adaptable learning strategy that may be developed around any specific area and integrated effectively into any practice context. PLPs are a natural method by which physicians learn. Parboosingh claims that learning through reflective practice is an effective way to improve a physician's practice and judgment, because:

- (a) People learn most naturally when faced with a problem solving experience
- (b) Learning that is constructed by the individual results in action.

6. 360° Review of Practice / Multi-Source Feedback (MSF).

Questionnaire forms are available for patients and colleagues to provide feedback. The objective of MSF is to identify strengths and areas for improvement in a doctor's practice so CPD can be aligned with learning needs.

References

1. Parboosingh, JT. 2002. Physician communities of practice: where learning and practice are inseparable. *Journal of Continuing Education in the Health Professions* 22(4): 230-236.
2. Campbell C et al. 1999. Study of the factors influencing the stimulus to learning recorded by physicians keeping a learning portfolio. *Journal of Continuing Education in the Health Professions* 19:16-24.

NOTE ON CONFIDENTIALITY AND THE INFORMATION PROVIDED IN THE PDR

It is possible that the Professional Development Review could be deemed a Quality Assurance Activity (QAA) under section 52 of the Health Practitioners Competence Assurance Act 2003. Your organisation (if you are working in solo practice) or your employee could apply for the Professional Development Review to be recognised as a protected QAA (PQAA) under section 53 of the Act. For further information on QAA visit the Ministry of Health's site:

<http://www.health.govt.nz/our-work/regulation-health-and-disability-system/health-practitioners-competence-assurance-act/quality-assurance-activities-under-act>



The Service Development Survey

PURPOSE

The Royal Australasian College of Physicians (RACP) encourages all Fellows to participate in a Regular Practice Review activity. Regular Practice Reviews are not a mandatory requirement of an accredited CPD programme; however, they are a desirable component of continuous learning and professional development programmes.

Completing a SDS, which is a component of the Regular Practice Review, will assist you in meeting your Continuous Professional Development (CPD) requirements in relation to peer review / Regular Practice Review (RPR).

If you are not in a clinical role, but one which entails case or file review, this is still a clinical service requiring clinical competence.

THE KEY PRINCIPLES OF THE SERVICE DEVELOPMENT SURVEY

- The SDS outlines in broad terms the key elements of health delivery for a particular service. It does not propose to set standards however it does provide links to other documents that may inform the SDS process.
- Based on methodology, the SDS could be used by a single practitioner, applied to a single service, a department, or an entire hospital. It will provide insight into the health care or service delivery across a service area and the infrastructure that supports it and the Senior Medical Officers or senior physicians involved.
- The Professional Development Review is felt to be an integral part of maintaining an individual's skillset and ongoing learning. As such it is an integral part of the SDS.
- It is envisaged that the SDS process will also provide a method of disseminating information regarding commonality in practice in other services, clinics and hospitals.
- The benefit in completing a SDS is that it provides rich information on a macro level e.g. identifies the department's future requirements and on a micro level e.g. identifies how satisfied the physician may be with his/her current role. The information collected in this process would contribute to credentialing and CPD requirements.



THE APPROACH TO AN SDS

- There are nine components to the SDS. The initial review would examine if you are meeting these components and ensure that some or all of these components are maintained on a regular basis e.g. on an annual basis. Any potential gaps in the SDS need to be addressed in a planned manner: most likely through a Professional Development Plan.
- The SDS could be used as part of your credentialing process. A Regular Practice Review does not replace the credentialing process, as the objective of a SDS is to support you in progressing your own practice and identify individual learning needs.
- The process is primarily formative. The SDS's outcomes remain with the service: that is the information remains with you and your Reviewers.
- Any significant shortcomings identified relating to you or the practice environment systems remain the responsibility of the service reviewed. Records relating the SDS will not be retained by College staff apart from an acknowledgement that a SDS has been undertaken. These data are required to provide the Medical Council of New Zealand with broad statistics on RPR participation rates.

For further background on the Service Development Survey please refer to the [“RPR process, guidelines and forms”](#) document



Service Development Survey (SDS)

Name of person hospital or organisation being reviewed	Click here to enter text.
Name of Person(s) Reviewing	
Meeting Place	
Time & Date of Meeting	

Please provide some background material relating to your service to assist the Reviewers. If a solo practitioner, this should include what professional and administrative support that you have. If part of a service, provide the number of senior staff, trainees and number of clinical staff employed in your department. The number of clinical staff employed in the entire organisation would provide the Reviewers with some context relating to your department or service.

THIS PAGE CAN BE RETAINED AS EVIDENCE WHEN COMPLETING YOUR CPD RETURN.

You can gain CPD credits for participating in a SDS. As a Reviewer or Candidate you are engaging in a peer review activity that may be recorded under Category Five in RACP's MyCPD programme for 2016 and in Category 1 'Practice Review and Improvement' for 2017.



Instructions to the Candidate

Prior to meeting the Reviewer(s) please complete sections 1-9 below as part of your preparation. Send the completed document to your Reviewer(s) two to three days prior to your interview.

To assist you in completing this form, please refer to Supporting documents for Regular Practice Review below.

Instructions to the Reviewer(s)

Prior to the interview, familiarise yourself with the document and bring the document with you to the interview.

Read the information provided by the Candidate relating to his / her service as this will provide you with some context

SECTION 1: PEER REVIEW GROUPS

Minutes of meetings should be kept with clinical details and the decision-making process to form part of the medical record. These materials should validate your attendance and record your decision-making. Ideally a brief anonymised patient record should also be retained and be available for CPD recording purposes.

- Mortality & Morbidity meetings
- Complex / Difficult case conferences
- Multidisciplinary meetings
- Reflect on the cultural dimensions of a difficult case. Think about any whanau meetings/interactions that may involve cultural issues. Analyse Mortality & Morbidity data and identify any trends regarding differences across ethnic groups.

Record relevant Peer Review activities

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Record information relevant to systematic ongoing audit

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SECTION 4: SERVICE PERFORMANCE INDICATORS

Examples would include:

- First Specialist Appointment (FSA) waiting times
- Follow up waiting times
- Procedural waiting times
- You may wish to analyse waiting times, non-attendance data to identify any significant trends across ethnic groups and reflect upon how change may be implemented
- This may also include global clinical performance indicators as appropriate to the service, eg. percentage achievement of target door-to-needle times for ST elevation MI

Record information relating to service clinical performance indicators

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SECTION 5: RISK REGISTER

Key areas of interest are:

- Identify areas of potential clinical risk
- Potential risks in service structure e.g. workforce size and resources available
- Any potential interaction with the Health and Disability Commissioner/ACC

Record information relating to the risk register

SECTION 6: SERVICE DEVELOPMENT

Key areas of interest are:

- Immediate, intermediate and long- term plans that impact on the individual clinician
- Awareness or likely changes in demand such as funding, demography (ethnic populations within your catchment area), policy and technology
- Regular meetings of clinicians to review the service and its development – Regular working meetings (e.g. monthly business meetings) and less frequent high level overall reviews (e.g. Retreats)
- Service developments should be viewed through a cultural lens. For example, a transplant service would have particular issues relating to cultural practices around donors.

Record information relating to service development



SECTION 7: PERFORMANCE / SATISFACTION FEEDBACK.

Record Feedback from:

- Patients – particular attention should be given to patients from different ethnic backgrounds and their feedback
- Primary care providers
- Other secondary clinician groups – internal and external
- Non-medical providers (such as nursing, physiotherapy)

Record feedback from other sources

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SECTION 8: CULTURAL COMPETENCE

Cultural competence should be incorporated into each of the other components. Please refer to the examples provided under specific headings.

You may wish to record general observations below

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SECTION 9: PROFESSIONAL REQUIREMENTS AND DOCUMENTATION

For each staff member in the service/department review the following

- Annual Practising Certificate (APC) –
 - a current APC is held
 - any conditions on APC
- Professional indemnity is up-to-date
- Resuscitation certification is up-to-date, as appropriate to clinical practice
- Adherence to organisational policies – e.g. fire training, email policy, privacy policy
- Familiarization with Professional Codes of Conduct – eg:
 - Medical Council of New Zealand “Good Medical Practice” It may be accessed from the Medical Council of New Zealand’s website [here](#)
 - The College’s document “Supporting Physicians’ Professionalism and Performance” (SPPP) provides further guidance in relation to professional qualities. Information about SPPP is available [here](#).
- Having regard to section 118 (i) of [Health Practitioners Competence Assurance Act 2003](#): being a culturally, ethically and clinically competent health professional.
- Having regard to the organisation’s policies on conflict of interests. For more information relating to probity go to the section on “Acting honestly and ethically” in the Medical Council of New Zealand’s Good Medical Practice (see link above)

Item	Comments
APC	
Professional indemnity	
Resuscitation certification	
Organisational policies <i>You may wish to note relevant policies</i>	
Professional Codes of Conduct <i>You may wish to note relevant policies</i>	



SUMMARY OF SERVICE DEVELOPMENT SURVEY

Reviewers to note key recommendations emerging from the review

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Final sign-off on completion of process	
Reviewer(s)	Candidate
Date	Date

Signatures	Signature
Add electronic signature or print and sign	Add electronic signature or print and sign



SUPPORTING DOCUMENTS TO INFORM THE SERVICE DEVELOPMENT SURVEY

a. Supporting Physicians' Professional and Performance (SPPP)

The relevant domains of the SPPP should be incorporated into the SDS.

The SPPP Guide is primarily a self-reflection form for use by individuals to help them understand their own performance. Although there may be many ways to use this framework, we anticipate most will use it proactively to plan their continuing professional development (CPD) activities.

Fellows and trainees may also utilise the SPPP Guide to improve their relationships with patients, colleagues and/or organisations. In some situations the SPPP framework may form the basis of discussions between colleagues or be used to contribute to an organisational performance development conversation.

The SPPP is designed to assist physicians in identifying good and poor Behavioural Makers in relation to a key set of professional domains.

[Click here](#) to download the SPPP guide.

b. Credentialing Framework

The Ministry of Health has produced several documents outlining the place of credentialing within the New Zealand health sector. The key document is "Toward Clinical Excellence: A Framework for the Credentialing of Senior Medical Officers in New Zealand". This document may be accessed by following the link below.

<https://www.health.govt.nz/system/files/documents/publications/clinical.pdf>

This document provides practical advice on credentialing.

<http://www.health.govt.nz/publication/credentialling-framework-senior-medical-officers-new-zealand-self-assessment-form>