Partnering for performance

A performance development and support process for senior medical staff

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A Victorian Government initiative

Victoria The Place To Be

Partnering for performance

A performance development and support process for senior medical staff

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Foreword

The Victorian Government is committed to ensuring the delivery of high quality health care. The Department of Health (the department) recognises that building engagement with senior medical staff is a key strategy for a high performance health care system.

One of the department's key initiatives to build clinical engagement is the *Credentialling and defining the scope of clinical practice for medical practitioners in Victorian health services policy* (Department of Human Services 2007). It provides guidance to health services in relation to the appointment of senior doctors. The formal re-credentialling process encourages and supports the ongoing relationship between doctors and their health service based on a mutual commitment to patient care.

The department has now developed *Partnering for Performance*, a performance development process for health services and doctors to use throughout the credentialling cycle to support senior doctors in the delivery of high quality care. *Partnering for Performance* provides opportunities for health services and senior doctors to continually monitor and improve clinical performance and to enable feedback to organisations about care delivery. Importantly, this new resource was developed with senior doctors, professional bodies and colleges.

The department looks forward to working with the health sector and the medical profession to implement *Partnering for performance* to help ensure high quality medical services in Victoria.

Acknowledgements

Partnering for performance was developed with considerable input from a range of stakeholders including health services. The Department of Health would like to thank all these people and in particular:

The DLA Phillips Fox consortium (including The Royal Australasian College of Medical Administrators and SACS consulting).

Members of the *Partnering for performance* steering committee and the Clinical engagement advisory group.

Contents

Policy

Contents

Executive summary

The Department of Health (the department) is committed to supporting the engagement of senior doctors to ensure the delivery of high quality health care in our hospitals. The department recognises that high quality care requires shared goals developed in a collaborative, supportive organisational culture, based on mutual responsibility for patient care.

Senior doctors work in complex environments and their performance is subject to an extensive range of influences from patients, peers, health care organisations and professional and regulatory bodies. The department recognises that despite this complexity, the vast majority of doctors are providing outstanding clinical services.

The department's existing *Credentialling and defining the scope of clinical practice for medical practitioners in Victorian health services* policy (Department of Human Services 2007) provides guidance to health services in relation to the appointment and ongoing employment of senior medical staff (including dentists).

Partnering for performance is a performance development and support process which supports the implementation of the credentialling policy. It aims to strengthen the relationship between senior doctors and their health services. It provides a suite of processes and tools to support clinical practice and to assist in the review of a senior doctor's performance with goal setting in four domains:

- work achievement (including clinical practice)
- professional behaviours
- learning and development
- career progression.

The *Partnering for performance* policy includes a *guide* which provides tips and checklists to assist participants in reviewing performance, performance development conversations and goal setting. Pro forma documentation is also provided.

The *Partnering for performance* policy incorporates the *Understanding clinical practice toolkit.* The *toolkit* provides guidance to a suite of common tools which enable individual doctors, their peers and organisations to understand and monitor clinical practice. The tools included are:

- peer review
- adverse occurrence screening/targeted case note review
- mortality and morbidity reviews
- clinical audit
- clinical indicators
- patient satisfaction and complaints.

The use of the *Partnering for performance* policy supports the regular monitoring of a doctor's performance throughout the credentialling cycle. It provides guidance to organisations and senior doctors to assist in enhancing performance, and where needed, identifying potential underperformance.

Partnering for performance emphasises the partnership between senior doctors and health services. The format of *Partnering for performance* allows for flexible application in health services, responsive to local circumstances.

Health services are required to have fully implemented the *Credentialling and defining the scope of clinical practice for medical practitioners in Victorian health services* policy (Department of Human Services 2007) by October 2012. As part of this implementation process it is expected that health services will also have a performance development and support process in place for regular review of the performance of their senior doctors by October 2012. Organisations that already have existing processes established should ensure that their processes align with the principles of *Partnering for performance*.

Introduction

In 2007, the Department of Human Services, now the Department of Health (the department) released the *Credentialling and defining the scope of clinical practice for medical practitioners in Victorian health services* policy (Department of Human Services 2007). The policy provides guidance to hospitals in relation to the appointment and ongoing employment of senior medical staff and was updated in 2009.

The policy recognises that regular review of a doctor's scope of clinical practice throughout the credentialling cycle is critical to the ongoing relationship between the doctor and organisation, as senior doctor skill sets and organisational requirements and capabilities evolve over time. Senior doctors work in complex environments and their performance is subject to an extensive range of influences from patients, peers, health care organisations and professional and regulatory bodies. Ongoing communication about clinical care ensures that organisations and senior doctors are collaborating around a shared commitment to enhancing patient care.

To support this process of regular review, the department, together with its Clinical engagement advisory group (CEAG)[1], developed *Partnering for performance* for senior doctors in Victorian public health services. It provides consistent processes and tools which support and enhance the relationship between the doctor and their employing organisations through focusing on patient care, whilst providing an opportunity to identify areas for potential improvement.

Partnering for performance is a performance development and support process. The *guide* provides tips, checklists and pro forma documentation to assist participants in reviewing performance, performance development conversations and goal setting.

In addition, the department recognises that senior doctors and organisations need to have the ability to understand an individual's clinical practice in order to maximise the effectiveness of performance development processes. The use of high quality clinical information to inform an understanding of patient care is critical to the ongoing development of our health care system and to ensuring a patient centred focus.

To support a comprehensive understanding of an individual's practice and to inform the performance development process, the department developed the *Understanding clinical practice toolkit*. The *toolkit* is provided here as part of *Partnering for performance*.

This *toolkit* provides guidance to a suite of common tools for use by senior doctors in Victorian public hospitals. The tools included are:

- peer review
- adverse occurrence screening/targeted case note review
- mortality and morbidity reviews
- clinical audit
- clinical indicators
- patient satisfaction and complaints.

[1] The Clinical engagement advisory group (CEAG) is an expert advisory group that includes representatives from across the health sector and the department including senior doctors, colleges and industry. The group advised on the development of the policy and oversees and informs a range of projects designed to enhance the ongoing relationship between organisations and their senior medical staff.

There are existing measures in place which provide an organisation or system level view of patient care and its underpinning systems (for example, root cause analysis, AusPSIs – patient safety indicators, Victorian health incident management system (VHIMS)) but they are not designed to provide information about an individual's practice.

In the development of these processes, the department recognises that the majority of doctors are providing outstanding clinical services, but a small percentage of doctors will occasionally underperform. The use of the *Partnering for performance* policy supports the process of regular review of a doctor's performance throughout the credentialling cycle and provides guidance to organisations and senior doctors to assist in enhancing performance.

A series of scenario based case studies are provided to highlight how the *guide* to performance development and the tools in the *Understanding clinical practice toolkit* can assist in the implementation of *Partnering for performance*.

Partnering for performance emphasises the importance of the partnership between senior doctors and health services. Health services have obligations to their senior doctors, just as senior doctors have responsibilities and accountabilities to the health services which employ or engage them.

Policy context

All senior doctors in Victorian public hospitals are required to undergo a formal credentialling and scope of practice process on appointment to a health service as outlined in the *Credentialling and defining the scope of clinical practice for medical practitioners in Victorian health services* policy (Department of Human Services 2007). The policy also stipulates that re-credentialling should occur at least once every five years. Thus all senior doctors remain in a 'credentialling cycle', at the completion of which they should undergo a formal re-credentialling process.

The ongoing monitoring of performance by doctors with their organisations is a critical element of the credentialling cycle. Over the course of the credentialling cycle, and with the appropriate use of *Partnering for performance*, senior doctors working with their organisations should be able to develop an ongoing, clear and comprehensive picture of clinical and professional performance. The ongoing nature of this relationship will mean that re-credentialling processes should operate on a 'no surprises' basis.

Partnering for performance is not only embedded within the *Credentialling and defining the scope of clinical practice for medical practitioners in Victorian health services* policy (Department of Human Services 2007), but also supports the *Clinical governance policy framework* (Department of Human Services 2008). Clinical governance is the system by which organisations and clinicians share responsibility and accountability for the quality of care. An effective system of clinical governance is essential to ensure continuous improvement in the safety and quality of health care.

The department's *Clinical governance policy framework* (Department of Human Services, 2008) has four domains: *consumer participation, clinical effectiveness, effective workforce* and *risk management.* One of the key principles of this framework is the measurement of performance. The *clinical effectiveness* domain identifies the use of tools such as peer review and clinical audit as a key strategy to evaluate and improve clinical performance. The *risk management* domain requires organisations to have strategies in place for reporting and investigation of clinical incidents, as well as systems for managing complaints.

Senior doctor participation in *Partnering for performance* provides an opportunity to inform and support organisational clinical governance processes. Performance development processes should also link with existing peer review and clinical audit processes, confirming participation and appropriateness of outcomes.

Performance development and support processes for senior doctors should not be established in isolation from other health service, college and statutory policies and programs. These processes should be integrated with existing policies to maximise benefits and minimise duplication.

The credentialling cycle should thus provide opportunities for senior doctors and organisations to highlight potential areas for clinical improvement and service development. In addition, ongoing support for the elements of the credentialling cycle should assist organisations in their attempts to meet regulatory requirements (for example, accreditation) and for doctors to meet their continuing professional development (CPD) requirements.

Partnering for performance is compatible with the *Victorian Charter of Human Rights and Responsibilities Act 2006.*

The following diagram illustrates the links between *Partnering for performance*, the *Credentialling and defining the scope of clinical practice for medical practitioners in Victorian health services* policy (Department of Human Services 2007) and clinical governance processes.

Credentialling cycle

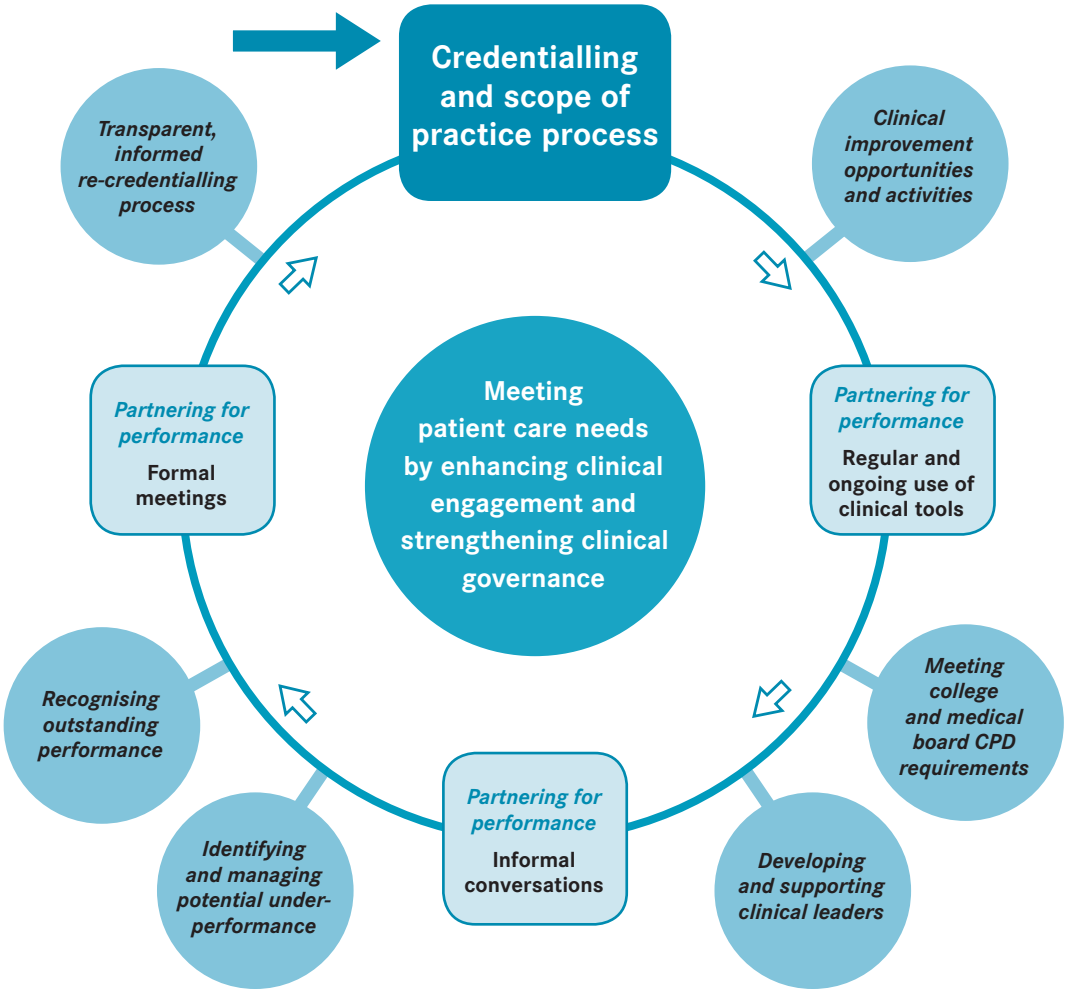

Figure 1. Credentialling cycle

The credentialling cycle integrates multiple processes, becoming a continuous cycle of re-credentialling and review of scope of clinical practice (every three to five years). The cycle is interspersed with regular informal and formal performance development conversations and routine participation in clinical review activities.

The following table provides a timeline for individual doctor's participation in the credentialling cycle.

Table 1. Credentialling cycle timeline for individual doctors

Activity	Timeframe
Credentialling, define scope of clinical practice Appointment to health service – confirm participation in performance development and support process Confirm college CPD requirements	Pre-appointment and at appointment
Establish initial performance goals	At appointment
Informal performance conversations	Commencing month 1 and ongoing
Participation in clinical audit, peer review and other quality activities; use *Understanding clinical practice toolkit*	Continuous in accordance with organisational policy and good professional practice
Formal performance development and support conversation scheduled and preparation completed	Year 1, month 11
Formal performance conversation held; goals set for coming 12 months	Year 1, month 12
Doctor to renew registration and comply with college CPD requirements	Commencement of years 2–3 (or up to year 5 if agreed)
Participation in clinical audit, peer review and other quality activities; use *Understanding clinical practice toolkit*	Continuous throughout years 2–3 (or up to year 5 if agreed) in accordance with organisational policy and good professional practice
Informal performance conversations	Ongoing
Formal performance conversation held; set goals for coming 12 months	Months 11–12 each year unless otherwise agreed
Undertake re-credentialling; re-define scope of clinical practice	End of year 3 (or up to year 5 if agreed)

Purpose

The aim in developing *Partnering for performance* is to build on the clinical engagement achieved through the implementation of the *Credentialling and defining the scope of clinical practice for medical practitioners in Victorian health services* policy (Department of Human Services 2007) and to assist in the ongoing development of the critical relationship between senior medical staff and their organisation.

Senior doctors are key contributors to health care organisations. They have a critical influence on:

- the safety and quality of patient care
- the development of patient focused organisational cultures
- the overall success of the organisations in which they provide services.

Effective performance development and support processes are based on and underpin an understanding of shared priorities. By creating an environment in which feedback can be provided and goals set, performance development assists senior doctors and organisations to support each other to optimise performance.

Performance development processes facilitate the development of a collaborative workplace culture and ongoing communication between each senior doctor and the organisation (usually represented by the medical lead such as the medical director, unit head or equivalent). They optimise individual and organisational performance through the following processes:

- recognising achievement and encouraging continuous improvement
- giving and receiving feedback about performance
- establishing clarity about performance expectations and direction
- developing realistic, mutually agreed, appropriate goals and relating them to the objectives and plans of the health service
- providing a structure to support staff, irrespective of levels of achievement
- planning education and professional development opportunities to maintain, improve or develop a senior doctor's performance
- determining opportunities and suitability for career progression.

Elements of effective performance development and support processes

Effective processes involve:

- clarification of performance objectives and expectations (for example, tasks, outcomes, behaviours, values based systems)
- formal periodic performance appraisal of individuals or teams against the achievement of set objectives
- ongoing informal feedback on what is going well and what can be improved
- recognition and/or reward for performance
- capability building at the team and individual level
- coaching or other action to deal with developmental areas
- development of particular capabilities linked with organisational need. (Australian Public Service 2001)

Benefits of performance development and support processes

Research demonstrates that managers have significant power to improve the performance of people who report directly to them by:

- emphasising performance strengths during formal reviews
- providing fair and accurate informal feedback
- being knowledgeable about employee performance
- providing feedback that helps employees do their jobs better
- providing opportunities to give feedback about the organisation.

There is strong evidence that good performance development and support processes:

- increase attraction and retention
- increase career optimisation
- increase discretionary effort
- increase productivity.

Conversely, there is also strong evidence that poor performance development processes are worse than no processes, because they can convey negative messages or can be perceived as simply paying 'lip service'.

In developing *Partnering for performance*, the department has been conscious of the need to ensure that its use, in the manner described, will:

- further assure the community of the high quality of care being delivered in our hospitals
- provide guidance to organisations as they actively support senior medical staff in their clinical work
- assist organisations and senior medical staff to achieve shared goals around patient care
- assist senior doctors to meet their CPD requirements
- assist organisations to identify areas for clinical improvement
- assist organisations in ensuring they have effective systems of clinical governance in place
- assist in the early identification and support of doctors experiencing performance issues.

Continuing professional development

The department is aware of the requirement for senior medical staff to undertake CPD, both as a condition of the new National registration and accreditation scheme (from 1 July 2010) and increasingly, of the specialist colleges. A number of colleges have been consulted to ensure that the elements of *Partnering for performance* meet CPD needs. Participation in *Partnering for performance* activities should assist senior doctors in meeting their college CPD requirements, although doctors should clarify this with their college. In meeting college requirements, senior doctors will also be meeting the CPD requirements of the new Australian medical board (from 1 July 2010).

Development of *Partnering for performance*

In 2008, DLA Phillips Fox, in conjunction with the Royal Australasian College of Medical Administrators (RACMA) and SACS Consulting were appointed by the department to develop a performance development framework.

The process undertaken included a literature review and the development of an issues paper which informed workshops with health service representatives (these documents are available at www.health.vic.gov.au/clinicalengagement). Key stakeholders were consulted during the framework development and a number of health services and senior doctors reviewed the final document. The process was overseen by a steering committee (a sub-committee of the department's CEAG).

Partnering for performance is based on roles and competencies from the Royal College of Physicians and Surgeons of Canada CanMEDS competency framework currently used by many of the Australian specialist colleges in their curriculum and CPD programs (Frank 2005).

The seven CanMEDS roles have been adapted for the Victorian system and incorporated into four domains for *Partnering for performance*, as illustrated in the following table.

Table 2. CanMEDS roles and *Partnering for performance* roles and domains

CanMEDS roles	*Partnering for performance* roles	*Partnering for performance* domains
Medical expert	Clinical expertise	Work achievement
Manager	Goal setting, leadership, review, planning and evaluation	
Communicator	Supportive environment	Professional behaviours Career progression
Collaborator	Motivation and engagement	
Professional	Professionalism	
Health advocate	Health advocacy	
Scholar	Scholarship	Learning and development

Using the language of competency based models, similar to that which has already been adopted by many of the Australian specialist colleges, is expected to aid senior doctors' understanding and support for the process. It will also enable linking of performance development and CPD outcomes.

The critical components of the performance development and support process for individual doctors are:

- regular, ongoing, informal communication with their medical lead (medical director, unit head or equivalent)
- regular participation in clinical *toolkit* activities to aid greater understanding of their clinical practice
- a regular formal performance conversation with their medical lead (medical director, unit head or equivalent), at least annually, which creates an opportunity to provide mutual feedback and set goals for the future
- follow up of the actions and goals agreed during that conversation.

Partnering for performance is designed so that the monitoring and review of clinical performance is a peer based process, undertaken through the use of tools such as clinical audit and peer review and occurring within the context of the credentialling cycle. Performance in the other roles of leadership, planning and evaluation, creating a supportive environment, motivation and engagement, professionalism and scholarship is monitored and developed during the regular dialogue between the doctor and their medical lead (medical director, unit head or equivalent). The outcomes of this monitoring and review contribute to the individual's broader performance development process.

Consistent with the wide variety of senior doctor appointment arrangements in health services across the state, *Partnering for performance* is intended to be flexible and adaptive. It suggests approaches and processes and offers supportive tools. The department recognises that some organisations are already undertaking similar processes. Organisations should ensure that their current approach to understanding performance aligns with the principles of *Partnering for performance.*

Guide overview

The *guide* outlines the performance development and support process and provides guidance as to how to prepare for and conduct regular performance development meetings. Tips and checklists and pro forma documentation are also included. The aim of the *guide* is to assist organisations to implement the policy and to support effective performance conversations.

A core element of the performance development and support process is the opportunity for goal setting. The *guide* outlines goal setting in each of the four domains; *work achievement, professional behaviours, career progression* and *learning and development*.

A key objective is to align each senior doctor's goals with the strategic goals of the organisation. For this to occur each senior doctor must:

- understand the health service's goals
- trust health service management
- be willing to engage with management in identifying and acting upon strategic opportunities.

However, in Australia there have been some expressions of disengagement of senior medical staff and a corresponding low level of congruence between the personal goals of individual senior doctors and health service goals. For these reasons garnering clinician support may require health services to actively seek to redress these issues.

In the *guide*, examples of competencies for senior doctors, the management team and the organisation are proposed for each of the performance development roles.

Information to support performance development and support meetings

Performance development processes may be informed by relevant agreed data or other information or lead to agreed actions that require analysis of data. Confirmation of a senior doctor's satisfactory participation in *toolkit* activities such as peer review and clinical audit, should be a key element of a performance development meeting. The process should not be based primarily on analysis of organisational or system level 'performance indicators'.

Data that will be used to inform performance development processes should be agreed in advance and there should be 'no surprises' stemming from the unplanned production of data at a performance development meeting.

It is important to ensure that information and data is able to be linked to college CPD and organisational clinical governance processes.

Multisource (360°) feedback

Multisource (360°) feedback is a tool for performance development which enables a senior doctor to receive structured feedback from their medical lead (medical director, unit head or equivalent) and a small number of peers, colleagues and patients. Multisource (360°) feedback is not, in itself, a performance development and support system, although it can be a useful tool in appropriate circumstances. Implemented effectively, with appropriate resourcing, support and training, it can assist senior doctors and organisations to gain valuable insights into performance across a range of roles and competencies.

Organisations need to exercise caution, however, if they are considering implementing a 360° feedback system for senior doctors. Significant disruption and harm can result from implementation that is inadequately resourced or that occurs in an environment in which people have not had positive experiences of performance development processes or where trust is lacking.

An organisation experienced in the successful implementation of performance development processes may consider if 360° feedback would enhance its processes, however, consideration needs to be given to:

- allocating sufficient resources to the process to facilitate its success
- selecting and/or developing the feedback tool, ensuring it is linked to organisational strategies and goals
- supporting implementation of the process through education of all participants (including those providing feedback) and other change management techniques
- processes for selecting the participants
- using the feedback
- integrating the process into the performance development and support system.

It is essential to the success of 360° feedback systems that people are assisted to understand the feedback they receive. This requires skilled facilitators to be available to support participants.

Management and organisational roles

Performance development and support processes for senior doctors create an opportunity to provide meaningful feedback to management and the organisation about the effectiveness of organisational support to enable senior doctors to undertake their work effectively.

It is not intended that this will result in a ‘performance review’ of the medical lead (medical director, unit head or equivalent) – that should occur in other settings and involve different participants. Rather, it is intended to enable structured discussion with the medical lead about how the management team and/or the organisation can work collaboratively with the senior doctor to support their effective performance.

Organisations should ensure that they have a process for collating and responding to feedback received from senior doctors through performance development processes. Existing organisational clinical governance policies and human resource processes may assist.

Understanding clinical practice toolkit overview

The *Understanding clinical practice toolkit* was developed in conjunction with the *guide*, by senior doctors with considerable clinical, management and policy experience. Support and guidance was provided by CEAG along with input from other key stakeholders.

A formal literature review was undertaken, to understand the evidence base for the use of the tools as a means of understanding clinical practice (this document is available at www.health.vic.gov.au/clinicalengagement). The literature has been used to guide the development of the *toolkit* and in particular, the recommendations around the utility and implementation of the various tools.

The *toolkit* is a practical outline of a suite of common tools for use by senior doctors and managers in Victorian public hospitals. The tools can be used to enhance the understanding of clinical practice at the individual senior doctor level and thus to support the process of regular review of a doctor's clinical practice throughout the credentialling cycle. In particular, these tools can assist in the assessment of a senior doctor as *clinical expert*, a component of the *work achievement* domain of the performance development process. The maximum benefit from these tools will be obtained when performance is regularly monitored over time.

The tools included are:

- peer review
- adverse occurrence screening/targeted case note review
- mortality and morbidity reviews
- clinical audit
- clinical indicators
- patient satisfaction and complaints.

A separate module is provided for each tool, including a description of the tool, a short summary of the literature relating to the tool, a 'how to' guide and recommendations regarding its use for the purpose of understanding an individual's clinical practice. Where necessary, the *toolkit* provides specific guidelines (the 'Victorian approach') in recognition of the need for standardised processes in order to maximise their value as an aid to understanding individual performance and to support clinical governance responsibilities.

In some situations, the *toolkit* provides cautionary advice about the use of particular tools, as there is potential for unintended consequences if the tool is not used in a consistent and appropriate way. Organisations and doctors should recognise the inherent limitations of a single tool being used in isolation.

The *toolkit* provides an approach to assist organisations in their efforts to understand and support clinical practice at the individual senior doctor level. The department recognises that there are a range of approaches and that many organisations are already undertaking elements of these activities. The *toolkit* is designed to support and encourage the further development and adaptation of these tools in the local context, using the provided description of the tool as a minimum expectation. Organisations currently using sophisticated approaches to understanding clinical practice such as cumulative sum (CUSUM) analysis should continue to do so where these approaches meet minimum criteria including:

- a clearly defined purpose
- consistent collection and management of data
- medical leadership of the process
- engagement of senior medical staff and peer input in the process.

Peer review

Oversight of professional practice by a peer is an important part of the maintenance and enhancement of a practitioner's clinical and professional skills and is an important technique in health care quality assurance and improvement. The processes of credentialling and defining scope of practice rely on doctors' willingness to participate in peer review activities. *Partnering for performance* further embeds formal peer review as a critical element of the re-credentialling process. In addition, formal peer review provides a means of formally and expertly assessing potential underperformance, where it becomes apparent that this is unable to be managed at the level of the doctor's medical lead (medical director, unit head or equivalent). The *toolkit* describes structured processes to support formal peer review. The peer review tool should be used in conjunction with the Australian Commission on Safety and Quality in Healthcare's *Peer review guide* (due for release in 2010).

Informal peer review involves peers providing ongoing oversight of each other's clinical care delivery. Informal peer review or peer support is a necessary element of all processes used to understand clinical practice. Examples include: peers informally discussing a case; the inter-specialist referral process; and participation in unit based pathology and radiology meetings where an individual clinician's cases are discussed in an open fashion. The *toolkit* provides structured opportunities for informal peer review through the use of morbidity and mortality meetings and adverse occurrence screening/ targeted case note review. Ongoing informal peer review is critical because a doctor's clinical performance should be interpreted and understood in the context of local health care needs, structures and processes.

Utility of the tools

For the purpose of understanding an individual doctor's clinical practice, some tools are more useful than others. Table 3. summarises the utility of these tools and provides guidance when deciding how much emphasis doctors and organisations should place on the information derived from use of the tool.

Table 3. Utility of tools in understanding an individual senior doctor's clinical performance

Tool	Utility of tool to assist in understanding clinical practice	Weighting
Formal peer review	• Strong evidence when organisations are using a properly designed and managed process • Major role in understanding possible underperformance and for re-credentialling	Strongly supported when structured and performed appropriately
Adverse occurrence screening/ Targeted case note review	• Good evidence when organisations are using a properly designed and managed ongoing process	Supported when structured and performed appropriately
Mortality and morbidity reviews	• Good evidence when organisations are using a properly designed and managed process	Supported when structured and performed appropriately
Clinical audit	• Good evidence when organisations are using a properly designed and managed process	Supported when structured and performed appropriately
Clinical indicators	• Limited ability to understand an individual doctor's practice	Should not be used in isolation to understand an individual doctor's practice
Patient satisfaction and complaints	• Limited ability to understand an individual doctor's practice • Repeated complaints or dissatisfaction which appear directly attributable to an individual senior doctor may imply underperformance and should initially be reviewed by the doctor's medical lead	Should not be used in isolation to understand an individual doctor's practice

The following tools have not been assessed as part of the *toolkit*, but the department provides the following recommendations for their use for the purpose of understanding an individual's clinical practice.

Table 4. Use of tools not included in the toolkit for the purpose of understanding clinical practice

Tool	Utility of tool	Weighting
Incident reporting	• Incident reporting currently lacks widespread uptake by doctors • Limited ability to assist in understanding an individual doctor's practice • Repeated incidents which appear directly attributable to an individual senior doctor may imply underperformance and should initially be reviewed by the doctor's medical lead	Should not be used in isolation to understand an individual doctor's practice
Root cause analysis (RCA)	• Process designed in the Victorian context for investigation of reported sentinel events • Sentinel events are relatively infrequent, clear cut events that occur independently of a patient's condition, commonly reflect hospital system and process deficiencies; and result in unnecessary outcomes for patients • RCA is designed to understand system level issues, not individual performance • Individual doctor performance issues detected in an RCA should be investigated separately from the RCA process	Should not be used in isolation to understand an individual doctor's practice

Organisational culture

In some health care organisations there is a dynamic and positive culture characterised by highly effective, continuous communication and feedback between management and senior doctors. In others, relationships are less well developed. The character of relationships may be influenced by a number of factors including:

- the existing organisational culture of the health service
- the nature of communication between management and medical staff
- the amount of time senior doctors are present at the health service
- whether senior doctors have full-time, part-time or contractor based appointments.

It is critical that health care organisations establish vital and positive relationships between management and senior doctors which are characterised by:

- a commitment to creating a culture which is focused on the delivery of high quality care
- transparency of communication and decision making
- mutual respect and trust
- an understanding of shared goals and objectives and a commitment to work together to achieve them.

Performance development and support processes represent one element of a complex set of relationships between senior doctors and their organisations. Performance development processes are necessary but not sufficient to support positive organisational cultures and relationships. Introducing these processes in isolation is unlikely to lead to sustainable culture change and may exacerbate existing tensions.

In such circumstances, performance development processes should be introduced carefully and in conjunction with other approaches to achieve sustainable improvement in relationships. For this reason, *Partnering for performance* is flexible and adaptive and can be implemented progressively depending on local circumstances.

The success of performance development and support processes are dependent upon the health service establishing a just culture, in which responsibility for patient care is shared. A just culture recognises that individual practitioners should not be held accountable for system failings over which they have no control. However, a just culture recognises that professionals are accountable for their individual actions and thus does not tolerate conscious disregard of clear risks to patients or gross misconduct (Marx 2001).

Critical to a successful process is a respectful and trusting relationship between senior doctors and their employing or contracting organisations, based on a mutual commitment to outstanding patient care. Organisations are encouraged to work with and support their senior medical staff to ensure the required level of engagement with and by medical staff. Organisations should ensure appropriate administrative and leadership support to allow the successful use of *Partnering for performance*.

Clinical leadership

Clinical leadership is critical to the delivery of high quality care. In *Developing the clinical leadership role in clinical governance* (2005) the Victorian Quality Council (VQC) describes clinical leadership as 'both a set of tasks required to lead improvements in the safety and quality of health care, and the attributes required to successfully carry this out' (VQC 2005, p.2).

VQC emphasises the importance of clinical leadership:

> Visible and active clinical leaders can assist in creating a safety and quality driven culture that achieves positive and sustainable improvements for patients, whilst driving processes that fulfil the clinical governance obligations of health services. Clinician input into safety and quality improvement is critical for maximising the 'bedside impact' of changes through acting as role models, and for promoting new ideas within and across clinical and professional boundaries. It is also vital for sustainability of change, as clinicians are often part of the health service over a longer period than managers, with medical consultants, in particular, often able to take a long term view (VQC, 2005, p.2).

The department acknowledges that the development of multidisciplinary based approaches to clinical improvement is important and indeed should be encouraged as local clinical systems develop. However, medical leadership of matters related to senior doctors remains appropriate and desirable, to ensure professional support and uptake. It is thus important for organisations to ensure that all elements of the credentialling cycle as outlined in the *Credentialling and defining the scope of clinical practice for medical practitioners in Victorian health services* policy (Department of Human Services 2007) and the *Partnering for performance* policy are supported by appropriately resourced and capable medical leadership.

Understanding and managing potential underperformance

Partnering for performance provides guidance for assessing a senior doctor's performance. It has been developed recognising that the majority of senior doctors are providing outstanding clinical services whilst undertaking their work in a professional and proficient manner.

Performance development and support is a positive process – as opposed to 'performance management' which is sometimes negatively associated with a process that leads to employment termination. *Partnering for performance* is designed to recognise and reward good performance, establish mutual goals for the upcoming period and facilitate ongoing dialogue between doctors and their organisations.

Most senior doctors will progress through their credentialling cycle with no major issues or concerns, and the process will enhance engagement with and by their organisations through the ongoing and active support of their clinical practice. However, a small number of doctors will, for a range of reasons, develop performance issues. *Partnering for performance* may assist in identifying underperformance.

Underperformance can be defined in a number of ways, but generally constitutes performance at a lower level than is expected of the individual given their qualifications, experience and past performance. To ensure procedural fairness it is important to establish what would constitute underperformance at the time of initial appointment or re-credentialling or soon thereafter. Doctors should have a clear understanding of what is expected of them based on their defined scope of practice, their position description or contract and relevant organisational and other policies (for example, codes of conduct).

Processes to address concerns about underperformance should be initiated at the time it is identified, rather than waiting for a scheduled performance development meeting or for re-credentialling. The principle of 'no surprises' should apply to re-credentialling and the formal performance development meetings.

If underperformance has been identified and raised with a senior doctor it should initially be managed by the doctor's medical lead (medical director, unit head or equivalent). In most cases investigation and remediation can occur at the local level when doctors work with their medical lead to understand the issues impacting on their performance (for example, personal issues or illness), and devise strategies to deal with those issues (such as referral to a general practitioner or time off work). There may be agreement for more frequent and closer monitoring of performance using the performance development and support processes.

In rare circumstances it may become apparent that there is underperformance which represents such a significant departure from professional practice, that escalation to an organisational level response is appropriate. This should occur under the guidance of the organisation's credentialling and scope of practice policy. The organisation will need to consider whether the case can be dealt with through formal peer review processes or whether notification to external agencies such as the medical board or the police is required.

The following diagram illustrates how *Partnering for performance* may assist in managing underperformance.

Identifying and managing potential underperformance

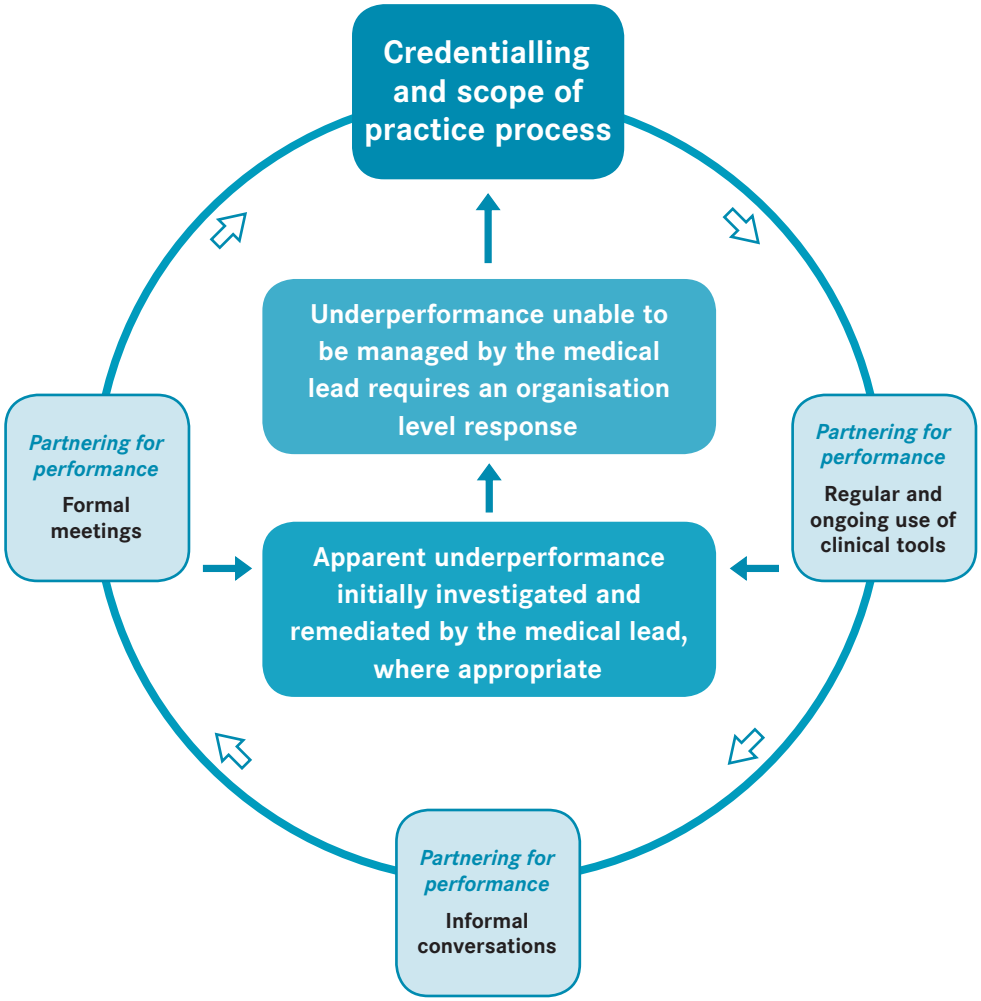

Figure 2. Identifying and managing potential underperformance

Partnering for performance may, through the use of clinical tools and ongoing performance conversations, suggest the possibility of underperformance. Where possible, apparent underperformance should be initially investigated and if necessary, remediated with the senior doctor's medical lead.

Records, confidentiality and privacy

Each health service should have a policy outlining how performance development documentation is to be managed. Agreement as to the arrangements for maintenance of records, confidentiality and privacy require a high level of trust. For this reason the policy should be developed with appropriate consultation with the senior medical staff group so that participants are aware of how the associated documentation will be managed and stored prior to the commencement of performance development processes.

The policy should address what documentation will be maintained, how and where it will be stored and who will have access to it. For example, documentation may be securely stored in the human resources department, in the medical management department or by the medical lead (medical director, unit head or equivalent) responsible for performance development processes.

The *Partnering for performance* documentation, which is signed off after a formal performance development meeting, must become part of the employment record of the senior doctor, as it is clearly of relevance for future re-credentialling and review of scope of clinical practice. If performance issues have been identified, a summary of the concerns and actions taken to address them should be included in performance development documentation.

The policy should also identify how de-identified, aggregated feedback from senior doctors will be collated and used to improve health service systems.

Future developments

A wide consultation process has been undertaken to ensure that *Partnering for performance* is appropriate and meets the needs of senior medical staff and their organisations, in supporting the *Credentialling and defining the scope of clinical practice for medical practitioners in Victorian health services* policy (Department of Human Services 2007) and the *Clinical governance policy framework* (Department of Human Services 2008).

It is intended that the *toolkit* modules will be updated and modified as new evidence emerges, or as clinical practices change. As organisational culture evolves and care delivery becomes increasingly multidisciplinary team based, performance development processes will need to be modified.

The department welcomes feedback about *Partnering for performance* and the broader clinical engagement program. Further information about the department's clinical engagement program is available from the website: www.health.vic.gov.au/clinicalengagement.

Guide

Contents

Credentialling cycle timeline for individual doctors

Activity	Timeframe
Credentialling, define scope of clinical practice Appointment to health service – confirm participation in performance development and support process Confirm college CPD requirements	Pre-appointment and at appointment
Establish initial performance goals	At appointment
Informal performance conversations	Commencing month 1 and ongoing
Participation in clinical audit, peer review, other quality activities; use *Understanding clinical practice toolkit*	Continuous in accordance with organisational policy and good professional practice
Formal performance development and support conversation scheduled and preparation completed	Year 1, month 11
Formal performance conversation held; goals set for coming 12 months	Year 1, month 12
Doctor to renew registration and comply with college CPD requirements	Commencement of years 2–3 (or up to year 5 if agreed)
Participation in clinical audit, peer review, other quality activities; use *Understanding clinical practice toolkit*	Continuous throughout years 2–3 (or up to year 5 if agreed) in accordance with organisational policy and good professional practice
Informal performance conversations	Ongoing
Formal performance conversation held; set goals for coming 12 months	Months 11–12 each year unless otherwise agreed
Undertake re-credentialling; re-define scope of clinical practice	End of year 3 (or up to year 5 if agreed)

Performance development and support cycle

The *Guide* provides information to help senior doctors and their medical lead (medical director, unit head or equivalent) to prepare for and undertake performance development meetings.

Schedule	Action
At the introduction of the program	All senior doctors are provided with a copy of the relevant sections of the *Guide*.
1 month before meeting – schedule meeting	The medical lead schedules a meeting with the senior doctor (of at least one hour).
	The medical lead confirms the time and place of the meeting with the senior doctor.
	The medical lead sends the senior doctor the agreed documentation from the last performance cycle, the *pro forma* documentation for the coming meeting with the identification information completed, a copy of the three competency tables (senior doctor, management team and organisation) and *Tips and checklists for senior doctors*.
2 – 3 weeks before meeting – preparation for the meeting	The senior doctor reads the documentation, including the competency tables, which can provide guidance with goal setting. The senior doctor reviews any performance development plans from the previous year.
	The senior doctor completes the form: • Part 1 – Period under review: achievements, challenges and actions. • Part 2 (a. to d.) – Goal setting for the coming period. • Part 3 – Creating the right environment.
	The senior doctor collates other agreed, relevant information including, for example, evidence of participation in CPD, clinical audit and peer review.
	The medical lead reviews performance development documentation for the senior doctor from previous years. The medical lead reflects on potential goals for the senior doctor for the coming year and on how the organisation is supporting the senior doctor's performance.
1 week before meeting – confirmation of performance development meeting	The medical lead confirms with the senior doctor the time and location for the meeting.
	The senior doctor and medical lead review respective checklists to ensure good preparation for the meeting.
	The senior doctor forwards a copy of draft completed pro forma to the medical lead.
	The medical lead reviews draft documentation in preparation for the meeting.

Schedule	Action
Performance development meeting	The medical lead and senior doctor bring the documentation from the previous performance cycle.
	The meeting is conducted in line with *Partnering for Performance* principles (refer to tips and checklists for effective performance conversations).
	The medical lead and senior doctor discuss the documentation and establish agreed actions.
	The medical lead and senior doctor each receive a copy of the completed forms.
Within 1 week of the meeting	The senior doctor provides a signed copy of the completed forms to the medical lead for their signature (Part 4). A copy is provided to the senior doctor. A copy is retained by the medical lead which is filed and secured in accordance with the protocol agreed with the SMS group and established by the health service.
At the conclusion of the annual performance development and support cycle	The medical lead and the health service management team review the aggregate de-identified feedback about health service performance, consider whether there are cross-unit or organisation-wide implications and develop actions to improve health service systems where appropriate.

Performance development and support *pro forma*

The following *pro forma* is for use by senior doctors and their medical leads (medical director, unit/department head or equivalent) in the annual, formal performance conversation. It facilitates:

- efficient and effective review of achievements against previously agreed goals
- mutual feedback about issues affecting the senior doctor's work and/or achievement of the organisation's goals
- establishment of goals for the forthcoming period
- agreement on any actions that need to be taken and how their achievement will be assessed.

Name of senior doctor

Name of medical lead (medical director, unit head or equivalent)

Role and classification

Period under review

Date of review

Part 1: The period under review – achievements, challenges and actions

Part 2: Goal setting for the coming period

- Create and agree goals for the coming period for each of the four domains.
- There should be two to three goals for each which may be drawn from the senior doctor competency framework.
- The draft goals should be developed by the senior doctor before the performance development meeting and discussed, refined, agreed and incorporated in the final documentation of the meeting.

Part 3: Creating the right environment

- Consider how the organisational systems that support the senior doctor to provide clinical services have impacted on their performance during the period under review.
- Before the performance development meeting, the senior doctor should consider which systems are working well and which could be improved. These suggestions should be discussed, refined, agreed and incorporated in the final documentation of the meeting.

Part 1: The period under review – achievements, challenges and actions			
Your achievements during the period under review	**Outcomes arising from your achievements**	**Challenges you faced during the period**	**Actions to address the challenges**
	→	→	→

Part 2: Goal setting for the coming period – *(a) Work achievement domain*				
To be completed now			**To be completed at next meeting**	
Goal description	**Action(s) – what needs to be done for you to achieve this goal?**	**Measure – how will it be determined if this goal has been achieved?**	**Has this goal been achieved?**	**Comments**
	→	→		→

Some possible *Work achievement* competencies include:

- Goal setting and leadership – contribute to the effective and efficient operation of your unit by undertaking agreed caseloads.
- Clinical expert – consistently provide high quality care.
- Review and evaluation - participate in unit audit activities to identify areas for improvements in clinical practice.
  (The *Understanding clinical practice toolkit* provides detailed guidance about tools to use in review of clinical practice.)

Consider *Work achievement* goals which relate to:

- Doing your work as well as possible.
- Helping your colleagues to work effectively in a team.
- Helping the health service to meet patient care goals.

Part 2: Goal setting for the coming period – *(b) Professional behaviours domain*				
To be completed now			To be completed at next meeting	
Goal description	Action(s) – what needs to be done for you to achieve this goal?	Measure – how will it be determined if this goal has been achieved?	Has this goal been achieved?	Comments

Some possible *Professional behaviours* competencies include:
- Engage with and support the organisation.
- Lead and coach junior staff and medical students.

Consider *Professional behaviours* goals which relate to:
- Collaboration and support for colleagues.
- Improving your work satisfaction.
- Working with your colleagues to advocate for better health services for your community.
- Ensuring the work place is a safe environment.

Part 2: Goal setting for the coming period – *(c) Learning and development domain*				
To be completed now			To be completed at next meeting	
Goal description	Action(s) – what needs to be done for you to achieve this goal?	Measure – how will it be determined if this goal has been achieved?	Has this goal been achieved?	Comments

Some possible *Learning and development* competencies include:
- Undertake teaching, supervision and assessment.
- Identify and accept opportunities to participate in medical research.

Consider *Learning and development* goals which relate to:
- Maintaining your professional knowledge and competence.
- Supporting the professional development of your junior colleagues.
- Helping the health service to identify and integrate improvements in clinical practice.

Part 2: Goal setting for the coming period – *(d) Career progression domain*				
To be completed now			**To be completed at next meeting**	
Goal description	**Action(s) – what needs to be done for you to achieve this goal?**	**Measure – how will it be determined if this goal has been achieved?**	**Has this goal been achieved?**	**Comments**

Some possible *Career progression* competencies include:

- Manage your career and practice.
- Accept opportunities to develop leadership skills.

Consider *Career progression* goals which relate to:

- Your career development and ambitions.
- Different stages of your career - for example, establishment and consolidation of a specialist clinical practice; undertaking academic and research initiatives; leadership ambitions in the health service, the College or the broader profession; transitioning from mixed private/public practice to full-time public work or from full-time clinical work to a mix of clinical, teaching and leadership roles.
- Promoting succession planning in your department.
- Improving your feedback and support for junior colleagues.

Part 3: Creating the right environment

- Consider how the organisational systems that support the senior doctor to provide clinical services have impacted on their performance during the period under review.
- Before the performance development meeting, the senior doctor should consider which systems are working well and which could be improved. These suggestions should be discussed, refined, agreed and incorporated in the final documentation of the meeting.

To be completed now			**To be completed at next meeting**	
Management and organisation system improvements which would support better quality clinical care	**Action(s) – what needs to be done for this improvement to be achieved?**	**Measure – how will it be determined if this improvement has been achieved?**	**Has this improvement been achieved?**	**Comments**

Part 4: Final comments, observations and agreed actions

Senior doctor

Medical lead (medical director, unit head or equivalent)

The senior doctor and medical lead should agree on the goals, actions and ways in which achievement of the goals and system improvements will be evaluated when they are next reviewed. This *pro forma* then establishes an agreed action plan for the forthcoming period.

I agree with the outcomes of this review including the proposed actions

Signature of senior doctor

Signature of medical lead

Tips and checklists for senior doctors

Tips and checklists are provided to assist senior doctors to participate in effective performance development and support.

Information for senior doctors

Credentialling and defining the scope of clinical practice is a foundation of high quality care, ensuring that senior doctors are supported to deliver care in a clinical environment where patient needs and doctor skill sets are matched.

The Department of Health's (the department) *Credentialling and defining the scope of clinical practice for medical practitioners in Victorian health services* policy (2007) provides guidance to hospitals in relation to the appointment and ongoing employment of senior medical staff.

The ongoing monitoring of clinical practice by doctors with the support of their organisations is a critical element of the credentialling cycle – the three to five year process that all doctors undertake between formal re-credentialling processes.

Partnering for performance is a performance development and support process (incorporating the *Understanding clinical practice toolkit*) which has been developed to assist organisations and doctors. The department recognises that the vast majority of doctors are providing exemplary services and sees *Partnering for performance* as a mechanism to support and encourage outstanding clinical care, through ensuring an organisational focus on patient care.

As doctors undertake the credentialling cycle, they should expect to:

- engage in ongoing formal and informal dialogue with their organisation about their clinical practice, with opportunities to provide and receive feedback
- undertake a formal performance development and support meeting with their medical lead (medical director, unit head or equivalent) on at least an annual basis
- establish and be supported in achievement of goals in each of the four performance development domains (*work achievement, professional behaviours, career progression* and *learning and development*)
- undertake some form of episodic or preferably ongoing clinical audit throughout the credentialling cycle
- have their clinical care reviewed by their peers in a structured and consistent fashion (for example, through the use of appropriately structured targeted case note review and mortality and morbidity review meetings).

In addition, organisations will need to appropriately support the engagement of senior doctors by:

- supporting clinical leadership of the performance development process
- providing appropriate opportunities for doctors to feed back information about the organisation's strategy and processes
- assisting doctors with clinical audit and clinical review through the provision of appropriate resources
- ensuring that any data provided for the purposes of understanding clinical practice is appropriately managed and interpreted
- seeking doctors' active involvement in clinical improvement initiatives
- appropriately and sensitively managing patient complaints and patient feedback.

Senior doctors should also expect that participation in *Partnering for performance* during the credentialling cycle will assist in meeting their college and national registration continuing professional development (CPD) requirements.

In addition, the department recognises that for a variety of reasons some doctors will occasionally experience issues with their clinical performance. Usually these are able to be managed with their medical lead (medical director, unit head or equivalent). From time to time, however, significant concerns about performance may arise. These should be managed within the organisation's credentialling and scope of practice processes. A formal peer review may rarely be required – the *Understanding clinical practice toolkit* provides guidance on the use of formal peer review to assist with this process.

The following diagram illustrates the links between *Partnering for performance* (including the *Understanding clinical practice toolkit*), the *Credentialling and defining the scope of clinical practice for medical practitioners in Victorian health services* policy (2007) and clinical governance processes.

Credentialling cycle

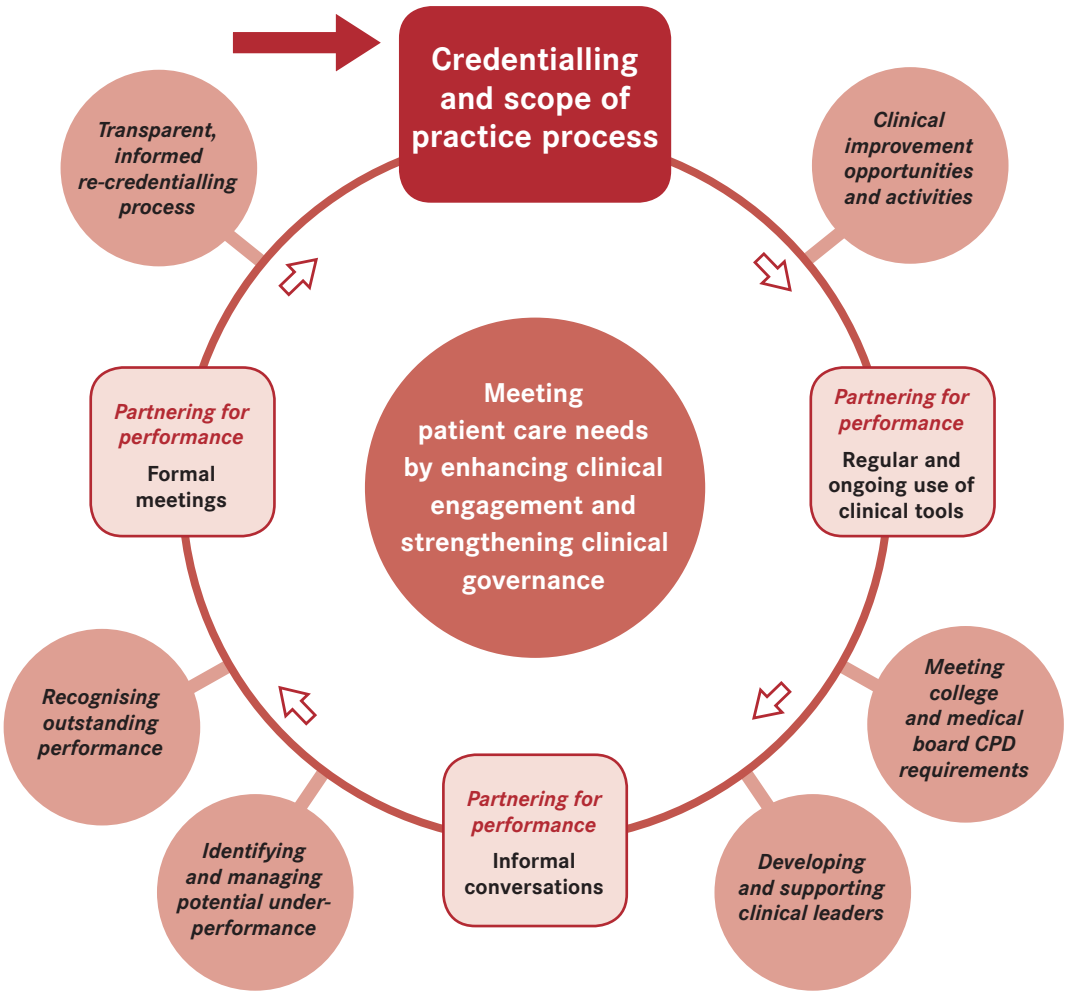

Figure 1. Credentialling cycle

The credentialling cycle assists doctors and organisations to meet professional and organisational needs, whilst supporting and promoting clinical leadership, and identifying and supporting clinical improvement opportunities.

Checklist for senior doctors to prepare for a performance conversation

Do I understand the organisational policy and procedures for performance development and support?	☐
Have I undergone appropriate learning to ensure I understand the purpose of and my role in the performance development and support process?	☐
Have I planned the performance development meeting appropriately, to make the most of the available time?	☐
Am I familiar with the organisation's strategies and objectives?	☐
Do I know where the performance development and support meeting is being held?	☐
Have I allowed sufficient time to participate in the meeting?	☐
Can I turn my pager or phone off for the duration of the meeting?	☐
Have I reviewed the documentation from the previous meeting?	☐
Have I done what I committed to do following the previous meeting?	☐
Have I considered potential positive feedback about the environment and the organisation that I can discuss with my medical lead?	☐
Have I completed and submitted the necessary pre-meeting documentation?	☐
Am I clear what information and data will be reviewed at the performance development meeting?	☐
Have I considered potential performance goals for the upcoming period that I can discuss with my medical lead?	☐
Have I considered whether there are actions that I or the organisation can take, to help me improve the way I provide services?	☐
Am I clear how the outcomes of the meeting will be documented and used?	☐

Checklist for understanding organisational strategy

A strategy is a plan of action designed to achieve a particular goal.

All Victorian public health services are required, at the direction of the Minister for Health, to prepare and submit to the Minister for approval a strategic plan for the operation of the public health service.

While they vary in form, most strategic plans will identify a vision, mission, values, strategic priorities/objectives and actions necessary to achieve those strategic priorities/objectives.

A strategic plan may cover a five to ten year timeframe.

The following is an example of a vision, mission, values and strategic priorities/objectives of a public health care service:

Vision	A healthier community through quality care, prompt access and effective partnerships
Mission	To apply our resources to work with our staff and partners, offering our diverse community excellence in health care
Values	A person-centred approach Excellence Compassion Integrity
Strategic objectives	Quality – to develop systems, processes and procedures to ensure consistently high quality
	Workforce – to maintain an environment that respects diversity, ensures equal opportunity and fosters excellent performance
	Governance – to demonstrate strong leadership, transparency and accountability for our stewardship of public resources
	Research and education – to be a learning institution in which education and research support and complement patient care

Each year, the health service will undertake a planning process to agree on how resources will be allocated in order to best progress achievement of its strategic objectives. Each unit may be asked to develop a plan that supports and is integrated into this annual business planning process. In addition, many health services will develop clinical quality plans that have a similar format. *Partnering for performance* is an opportunity for senior doctors to be made aware of and contribute to organisational strategy.

The senior doctor should consider the following questions about the organisation's strategic plan:

Am I broadly familiar with the vision, mission, strategic objectives and priorities of the organisation?	☐
Is it clear how my work contributes to achievement of the organisation's strategic objectives and priorities?	☐
Will the goals I am hoping to establish for the coming year be compatible with the organisation's strategic objectives and priorities?	☐
What could I or my unit do to help the organisation achieve its strategic objectives or priorities?	☐
Is there anything the organisation can do to make it easier for me to work towards achieving its strategic objectives or priorities?	☐

Important considerations in career planning

At the annual performance development meeting and at regular intervals throughout the year, it is important for the medical lead (medical director, unit head or equivalent) and senior doctor to discuss career planning and progression.

Career objectives and planning should reflect the seniority and interests of the senior doctor as well as the opportunities available to them. The following factors need to be taken into consideration:

- Practice establishment – in the early post-fellowship years career goals may be focussed on the development and consolidation of clinical practice.
- Academia and research – these may be relevant at any stage in a senior doctor's career.
- Professional leadership – every senior doctor should be encouraged to explore and take up opportunities for clinical leadership throughout their career – in the health service, the College or the profession more broadly.
- Transitional planning – at different stages in their career, senior doctors may consider transition from mixed private/public practice to full-time public work or from full-time clinical work to a mix of clinical, teaching and leadership roles.

The following points are important considerations for the career planning conversations between senior doctors and medical lead (medical director, unit head or equivalent).

- Senior doctors should assume responsibility for their career planning. The medical lead can assist and support them.
- Be prepared for the performance development and support meeting. Senior doctors should reflect on their work and career planning before they attend the meeting. If possible, arrive with a written plan or at least some key points about their aims and goals.
- Senior doctors should clearly articulate their career expectations to their medical lead and ask for the medical lead's comments or support.
- Ensure there is a mutual understanding between the senior doctor and medical lead as to the senior doctor's likes, dislikes, interests, ambitions and other relevant factors. It needs to be realistic – there will always be some aspects of work people won't find enjoyable. It is rare for people to enjoy every aspect of their job and some tasks might simply just need to be done.
- The senior doctor should offer their personal assessment of their own skills, abilities and potential and ask for their medical lead's assessment.
- At the same time, senior doctors can discuss growth and advancement and ask how further development would be possible in their current position.
- They should request ideas and support for overcoming any barriers to their career plan.
- Senior doctors need to be open to considering alternative goals and strategies. The medical lead might suggest options the staff member had not previously considered and they should allow themselves to explore a variety of ideas and suggestions.
- The focus of attention should be primarily on the next two to three years.
- The senior doctor and the medical lead need to work together to translate ideas into concrete steps within the scope of the senior doctor's present role.

Important considerations in setting goals

Research suggests that most people can cope comfortably with around five to seven goals, including measures. If you have more than this you end up with goals which do not change people's behaviour.

Good goals contain:

- a description of the goal so it is clear what it means
- an agreed measure to assess whether the goal has been reached.

They are:

- **S**pecific – clear as to what they mean and relate to
- **M**easurable – can be assessed
- **A**chievable – not too easy or too hard to be reached
- **R**ealistic – relate in a concrete way to what needs to be done
- **T**rackable – it should be clear in the course of the year as to how likely it is that the goal is going to be reached.

This does not mean that the goals necessarily need to be capable of objective measurement by a third party. Providing that the right level of trust exists between the two people setting the goals, they could be a mutually agreed rating, or even the supervisor rating, as long as they are mutually agreed and committed to. The test is whether the two people involved in the review can picture themselves sitting down one year later and agreeing whether the goal has been reached or not.

Generally, more specific and practical goals are best. It is harder to write goals in apparently abstract areas, such as 'professional behaviours'. This can be best done by building the goal around practical examples of how the characteristic is lived out at work. For instance if the behaviour sought is to be supportive of the professional development of less senior colleagues the examples might include:

- putting time aside each week to be available to answer questions from colleagues
- being welcoming and approachable for colleagues when they seek assistance
- following up on less senior colleagues' enquiries to ensure that the issue was resolved.

Whatever else, the goal must be mutually agreed in order for it to have any beneficial contribution to the behaviour of the staff member – imposed goals are notoriously ineffective in changing behaviour.

Performance development and support processes in environments where medical leads and senior doctors may have limited contact

It is not uncommon in some health care organisations for senior doctors and their medical leads to have little direct contact with each other. For example, senior doctors may have small fractional appointments, flexible working conditions or work in a different facility from their medical lead. The medical lead may then depend on feedback from others about how a senior doctor is performing across the various roles and competencies, and the medical lead and senior doctor may not have a strong underlying relationship because they do not have frequent direct contact.

Medical leads will need to consider how to overcome these obstacles to achieve successful performance development and support processes.

Problem/difficulty for medical leads	Actions which medical leads may utilise to overcome problem/difficulty
Medical lead is not a witness and it is hard to know how a person is performing.	• Build a network of trusted and impartial observers. • Set clear goals and focus on evidence rather than hearsay.
Underperformance requires special care and the employee may not be aware they are underperforming.	• Investigate the reason for underperformance. • Use their network to investigate the reason for underperformance. • Reallocate resources. • Approach human resources specialists for assistance. • Personally intervene and set goals and measures.
Trusted observers may just see the negatives and not feed back the positives and third parties tend to just give bad news.	• Communicate with their trusted observers the type of feedback they want to receive. • Recognise and reward good performance.
People have more opportunity to evade performance expectations.	• Establish clear and simple reporting lines.
Other team members can be very divisive if managing underperformance of one of their colleagues.	• Inform people higher up in the organisation what the medical lead is doing. • Encourage other team members to be part of the solution. • Network and consult with their colleagues.
Third parties may wish to remain confidential.	• Personally intervene in situation. • Ask third parties if they are prepared to go on ‘record’ (if required).
People are embedded in a peer group that is ‘not aligned’.	• Undertake team building exercises, articulating what the team stands for the purpose of the exercise and ground rules about how you will interact with each other.

Tips and checklists for medical leads (medical director, unit head or equivalent)

Tips and checklists are provided to assist medical leads (medical director, unit head or equivalent) to undertake effective performance development and support.

Checklist for medical leads to prepare for a formal performance conversation

Is there an organisational policy and procedure for performance development and support which is clear, accessible and understood by senior doctors and management?	☐
Has the senior doctor been made aware of the purpose of and their role in the performance development process?	☐
Have I undergone appropriate training in performance development and support?	☐
Have I planned the performance development meeting appropriately, so the senior doctor has had sufficient notice of the meeting's time and purpose?	☐
Have I booked a private room for the meeting with the senior doctor?	☐
Have I allowed sufficient time for the meeting with the senior doctor?	☐
Does the senior doctor know how much time is scheduled for the meeting?	☐
Have I reviewed the documentation from the previous meeting?	☐
Have I done what I committed to do following the previous meeting?	☐
Has the senior doctor been provided with documentation from the previous meeting which defines agreed goals?	☐
Has the senior doctor been asked to complete pre-meeting documentation, has it been submitted and have I reviewed it?	☐
Is there a suite of agreed information to support the performance development meeting, and is it available to both me and the senior doctor?	☐
Do I and the senior doctor have access to agreed information about his or her participation in clinical audit, informal peer review and other clinical toolkit activities to inform the performance development process?	☐
Am I confident that I will not be initiating any 'surprises' at the meeting, for which the senior doctor will be unprepared?	☐

Have I considered potential positive feedback that I can discuss with the senior doctor?	☐
Have I considered potential performance goals for the upcoming period that I can discuss with the senior doctor?	☐
Have I considered whether there are actions that I or the organisation can take, to improve the working environment for the senior doctor, which I can discuss with him or her?	☐
Have I considered the senior doctor career and professional aspirations, and how I or the organisation could support their achievement?	☐
Is the appropriate paperwork available to me so I can document the meeting in accordance with the performance development and support policy?	☐
Do I have a clear understanding of the organisational policy that defines how and where documentation will be stored?	☐

Tips on how to have an effective performance conversation

To improve performance the medical lead (medical director, unit head or equivalent) must help senior doctors to find tangible solutions to specific work challenges. Medical leads must provide needed information, resources and technology. Medical leads can be 'performance killers' by creating unclear or inconsistent expectations.

Maximise the impact:

- Focus on the positive – emphasising the positive in performance development meetings can have a substantial impact on employee performance. An emphasis on personal strengths has a positive impact on individual performance. Be knowledgeable about employee performance.
- Emphasise the future – looking to the longer-term during the formal review is a positive influence.
- An emphasis on weaknesses to the exclusion of other types of feedback can reduce individual performance substantially. 'Tough' feedback needs to be supported by specific suggestions for doing the job better.

Performance conversations should encompass the following:

Informal performance conversations	Formal performance conversations
Approach • Ongoing opportunities • Two way partnership • One on one	**Approach** • At least one documented performance development conversation per year, with form filed in accordance with organisational policy • Two way partnership • One on one
Content • Giving and receiving feedback • Evidence based • Opportunity to discuss progress • Opportunity to give good news or reinforce strengths • Opportunity to provide constructive advice, or alert to areas of development in performance or behaviours • Fair and accurate informal feedback on performance from knowledgeable sources is the most effective performance management tool available to the organisation • Feedback should be voluntary, detailed, immediate and positive • Ensures no surprises at the formal performance conversation	**Content** • Giving and receiving feedback • Evidence based • No surprises • Identify strengths and capitalise on them; emphasise the positives • Conversations about weaknesses must be focused on suggestions for improvement or development • Reviewing performance or looking back • Planning or looking forward and determining goals for the future that are specific, measurable, achievable, realistic and trackable (SMART) • Discussing how goals are achieved – values are important • Training and development plan – personal and professional
Documentation • A contemporaneous record of any agreed actions resulting from informal conversations. For example, email or letter from medical lead to senior doctor.	**Documentation** • Formal record of conversation including issues discussed, goal setting and actions arising. For example, *Partnering for performance* forms (or equivalent).

(Corporate Leadership Council 2002)

Checklist for medical leads to undertake performance conversations

A medical lead should consider the following before and during a performance development and support conversation:

- [ ] Am I well prepared for the meeting?
- [ ] Have I identified the goals of the meeting, at the beginning?
- [ ] Am I encouraging participation by asking open questions?
- [ ] Am I cognisant of the fact that individuals differ?
- [ ] Am I separating the person from their performance?
- [ ] Am I managing the 'tone' of the meeting effectively?
- [ ] Am I coaching rather than judging?
- [ ] Did I start with the positives?
- [ ] Am I being specific about behaviours (not personality traits)?
- [ ] Am I addressing the negatives with the aim of improving performance?
- [ ] Am I giving the senior doctor a chance to have their say?
- [ ] Am I looking to the future and linking it with development?
- [ ] Have I asked how I or the organisation can assist?
- [ ] Do I have a positive to end with?

Tips on delivering effective performance feedback

- Put the individual first – build trust; lead with the positive. How medical leads communicate is more important that what they communicate.
- Aim for self-evaluation – ensure ongoing, year round dialogue in relation to performance; aim for employee to already know if/when performance lapses. Ensure that during formal performance conversations there are 'no surprises'.
- Tolerate discord but be specific – focus on specific behaviours and their consequences. Performance dialogue is meant to provide a platform for improvement, not to highlight inadequacies.
- Set and reinforce objectives and make accountability explicit – employees should come away from a performance conversation knowing how behaviours need to be adjusted and what they should do differently. Effective dialogue involves agreeing specific objectives and follow-up dates. (Hay Group 2002)

Tips and techniques for difficult performance conversations

- Prepare in advance.
- Write down the words you will use.
- Rehearse.
- Be in control of yourself – keep your emotions under control.
- Give the person a chance to have their say.
- Avoid comments about the person.
- Focus on the behaviour and be specific.
- Stick to the facts – performance goals, measurements and progression criteria.
- Point the way ahead.

Checklist for understanding organisational strategy

A strategy is a plan of action designed to achieve a particular goal.

All Victorian public health services are required, at the direction of the Minister for Health, to prepare and submit to the Minister for approval a strategic plan for the operation of the public health service.

While they vary in form, most strategic plans will identify a vision, mission, values, strategic priorities/objectives and actions necessary to achieve those strategic priorities/objectives.

A strategic plan may cover a five to ten year timeframe.

The following is an example of a vision, mission, values and strategic priorities/objectives of a public health care service:

Vision	A healthier community through quality care, prompt access and effective partnerships
Mission	To apply our resources to work with our staff and partners, offering our diverse community excellence in health care
Values	A person-centred approach Excellence Compassion Integrity
Strategic objectives	Quality – to develop systems, processes and procedures to ensure consistently high quality
	Workforce – to maintain an environment that respects diversity, ensures equal opportunity and fosters excellent performance
	Governance – to demonstrate strong leadership, transparency and accountability for our stewardship of public resources
	Research and education – to be a learning institution in which education and research support and complement patient care

Each year, the health service will undertake a planning process to agree on how resources will be allocated in order to best progress achievement of its strategic objectives. Each unit may be asked to develop a plan that supports and is integrated into this annual business planning process. In addition, many health services will develop clinical quality plans that have a similar format. *Partnering for performance* is an opportunity for senior doctors to be made aware of and contribute to organisational strategy.

Before each performance conversation, the medical lead should consider the following questions about the organisation's strategic plan:

Have I recently reviewed a copy of the organisation's strategic plan?	☐
Do I have a clear understanding of the strategic plan and how my unit's work supports it?	☐
Have I considered how the work of each senior doctor in my unit contributes to achievement of the organisation's strategic plan?	☐
Am I demonstrating strong leadership with respect to the organisation's values?	☐

Important considerations in career planning

At the annual performance development meeting and at regular intervals throughout the year, it is important for the medical lead (medical director, unit head or equivalent) and senior doctor to discuss career planning and progression.

Career objectives and planning should reflect the seniority and interests of the senior doctor as well as the opportunities available to them. The following factors need to be taken into consideration:

- Practice establishment – in the early post-fellowship years career goals may be focussed on the development and consolidation of clinical practice.
- Academia and research – these may be relevant at any stage in a senior doctor's career.
- Professional leadership – every senior doctor should be encouraged to explore and take up opportunities for clinical leadership throughout their career – in the health service, the College or the profession more broadly.
- Transitional planning – at different stages in their career, senior doctors may consider transition from mixed private/public practice to full-time public work or from full-time clinical work to a mix of clinical, teaching and leadership roles.

The following points are important considerations for the career planning conversations between senior doctors and medical lead (medical director, unit head or equivalent).

- Senior doctors should assume responsibility for their career planning. The medical lead can assist and support them.
- Be prepared for the performance development and support meeting. Senior doctors should reflect on their work and career planning before they attend the meeting. If possible, arrive with a written plan or at least some key points about their aims and goals.
- Senior doctors should clearly articulate their career expectations to their medical lead and ask for the medical lead's comments or support.
- Ensure there is a mutual understanding between the senior doctor and medical lead as to the senior doctor's likes, dislikes, interests, ambitions and other relevant factors. It needs to be realistic – there will always be some aspects of work people won't find enjoyable. It is rare for people to enjoy every aspect of their job and some tasks might simply just need to be done.
- The senior doctor should offer their personal assessment of their own skills, abilities and potential and ask for their medical lead's assessment.
- At the same time, senior doctors can discuss growth and advancement and ask how further development would be possible in their current position.
- They should request ideas and support for overcoming any barriers to their career plan.
- Senior doctors need to be open to considering alternative goals and strategies. The medical lead might suggest options the staff member had not previously considered and they should allow themselves to explore a variety of ideas and suggestions.
- The focus of attention should be primarily on the next two to three years.
- The senior doctor and the medical lead need to work together to translate ideas into concrete steps within the scope of the senior doctor's present role.

Important considerations in setting goals

Research suggests that most people can cope comfortably with around five to seven goals, including measures. If you have more than this you end up with goals which do not change people's behaviour.

Good goals contain:

- a description of the goal so it is clear what it means
- an agreed measure to assess whether the goal has been reached.

They are:

- **S**pecific – clear as to what they mean and relate to
- **M**easurable – can be assessed
- **A**chievable – not too easy or too hard to be reached
- **R**ealistic – relate in a concrete way to what needs to be done
- **T**rackable – it should be clear in the course of the year as to how likely it is that the goal is going to be reached.

This does not mean that the goals necessarily need to be capable of objective measurement by a third party. Providing that the right level of trust exists between the two people setting the goals, they could be a mutually agreed rating, or even the supervisor rating, as long as they are mutually agreed and committed to. The test is whether the two people involved in the review can picture themselves sitting down one year later and agreeing whether the goal has been reached or not.

Generally, more specific and practical goals are best. It is harder to write goals in apparently abstract areas, such as 'professional behaviours'. This can be best done by building the goal around practical examples of how the characteristic is lived out at work. For instance if the behaviour sought is to be supportive of the professional development of less senior colleagues the examples might include:

- putting time aside each week to be available to answer questions from colleagues
- being welcoming and approachable for colleagues when they seek assistance
- following up on less senior colleagues' enquiries to ensure that the issue was resolved.

Whatever else, the goal must be mutually agreed in order for it to have any beneficial contribution to the behaviour of the staff member – imposed goals are notoriously ineffective in changing behaviour.

Performance development and support processes in environments where medical leads and senior doctors may have limited contact

It is not uncommon in the health care organisational environment for senior doctors and their medical leads to have little direct contact with each other. For example, senior doctors may have small fractional appointments, flexible working conditions or work in a different facility from their medical lead. The medical lead may then depend on feedback from others about how a senior doctor is performing across the various roles and competencies, and the medical lead and senior doctor may not have a strong underlying relationship because they do not have frequent direct contact.

Medical leads need to consider how to overcome these obstacles to achieve successful performance development and support processes.

Problem/difficulty	Actions to overcome problem/difficulty
You are not a witness and it is hard to know how a person is performing.	• Build a network of trusted and impartial observers. • Set clear goals and focus on evidence rather than hearsay
Underperformance requires special care and the employee may not be aware they are underperforming.	• Investigate the reason for underperformance. • Use your network to investigate the reason for underperformance. • Reallocate resources. • Approach human resources specialists for assistance. • Personally intervene and set goals and measures.
Trusted observers may just see the negatives and not feed back to you the positives and third parties tend to just give bad news.	• Communicate with your trusted observers the type of feedback you want to receive. • Recognise and reward good performance.
People have more opportunity to evade performance expectations.	• Establish clear and simple reporting lines.
Other team members can be very divisive if you are managing underperformance of one of their colleagues.	• Inform people higher up in the organisation what you are doing. • Encourage other team members to be part of the solution. • Network and consult with your colleagues.
Third parties may wish to remain confidential.	• Personally intervene in situation. • Ask third parties if they are prepared to go on ‘record’ (if required).
People are embedded in a peer group that is ‘not aligned’.	• Undertake team building exercises, articulating what you stand for as a team, your purpose and ground rules about how you will interact with each other.

Leadership checklist for medical leads

Leaders drive performance through impact on morale and the stress levels of their colleagues. Medical leads can increase senior doctor well-being and motivation, loyalty, retention and performance through a number of strategies. Concern about people as individuals and ensuring people understand your values and expectations are both important. Clarity builds morale and lessens workplace stress.

Medical leads should consider the following:

Do I demonstrate that I care about the future of the senior doctors who report to me?	☐
Do I show personal concern for the senior doctors who report to me?	☐
Do I demonstrate that I value (as individuals) the senior doctors who report to me?	☐
Do I demonstrate respect for the opinions of the senior doctors who report to me?	☐
Do I seek the views of the senior doctors who report to me, about issues that affect them?	☐
Do the senior doctors who report to me know what I stand for?	☐
Do the senior doctors who report to me know how their jobs contribute to achievement of the overall vision, mission and strategic objectives of the health service?	☐
Do the senior doctors who report to me know what standards of performance are expected of them?	☐
Are the senior doctors who report to me given the authority they need to deliver the outcomes they are responsible for – are they empowered?	☐
Are the senior doctors who report to me aligned with their colleagues – is there a feeling that we are all heading towards achieving the same goals?	☐
Are the senior doctors who report to me prepared to take on the goals of the health service – do they take ownership?	☐
Are the senior doctors who report to me developing their skills?	☐
Are the senior doctors who report to me developing their experience?	☐
Are the senior doctors who report to me developing their attitudes and values?	☐
Are the senior doctors who report to me optimistic that they will continue to learn?	☐

Effective goal setting and performance conversations can provide an opportunity to help achieve these outcomes.

Checklist for following up on agreed actions

Keeping commitments made to colleagues during performance development and support processes is essential to maintaining trust and confidence in the processes. This is important for both medical leads and senior doctors.

Documentation of agreed actions incorporating timeframes and reminders is a useful strategy to facilitate reliable follow up of agreed actions. The *pro forma* for the performance development meetings creates a complete record of the agreed actions. It can also be helpful, however, to maintain a record of any agreed outcomes of conversations that occur in between regular, planned meetings.

Medical leads and senior doctors should consider establishing a reliable system of documentation of agreed actions, to support follow up. A system may consist of an electronic or paper-based recording and reminder system which incorporates a number of elements. Medical leads and senior doctors should consider the following:

Do I have a system for recording the outcomes of informal performance development conversations including agreed actions arising from those conversations? ☐

Does my system create a written record of:

- the key aspects of each conversation? ☐
- what I agreed to do? ☐
- what the other party agreed to do? ☐
- the resources that would be made available to achieve the action? ☐
- the outcomes we were both anticipating? ☐
- the agreed timeframe for action? ☐

Does my system remind me to send a brief communication (for example, email) to the other party confirming the outcomes of the conversation and the agreed actions? ☐

Does my system remind me when due dates are pending? ☐

Does my system remind me to follow up with the other party to confirm that the agreed actions have been completed and the expected outcomes have been achieved? ☐

Using information gained during performance development and support processes

The performance development and support processes recommended in this framework create a formal opportunity for senior doctors to comment on the extent to which organisational systems support their delivery of services.

Individually identifying information should never be released from performance development processes, but information which does not identify individuals should be aggregated and assessed to identify opportunities to improve organisational systems.

Following each annual cycle of performance development meetings, medical leads should consider whether there are any recurring themes emerging from performance development and support conversations with senior doctors which should alert them to a systemic issue. At the end of each performance development and support cycle, medical leads and members of the health service management team should specifically consider the following:

Have I collated all of the agreed actions arising from Part 3: Creating the right environment?	☐
Are there any themes emerging from these agreed actions?	☐
If there are recurrent themes: • are there additional actions I need to take within my unit to address the issue of concern? • are there additional actions that need to be taken by other areas of the health service to address the issue of concern?	☐ ☐
Is there a process for me to consult with my medical lead colleagues to determine if there are recurrent themes across units and agree actions?	☐
Is there a process for medical leads to collectively meet with management to present/discuss the outcomes of the performance development cycle and agree on organisation-wide actions?	☐
Is there a process for senior management to be informed of the outcomes of senior doctor performance development processes and the proposed organisational response?	☐

Coaching skills for leaders

In helping staff to develop performance goals and focus on their development plans, coaching may be useful. Coaches may be internal or external to the organisation.

Key characteristics of coaching:

- Coaching is best suited to situations where the learning is conceptual, abstract, or interpersonal.
- It is focussed on learning, so it should enshrine adult learning principals and formulate goals that promote learning.
- It is focussed on making people more self-managing. The ultimate goal of coaching is for the coached to be able to self-coach; that is, to be self-managing and self-regulating. As well as ensuring that the coached has learned new skills and techniques, the coach and coached need to establish maintenance strategies so that the coached does not revert to earlier behaviours. There also needs to be ongoing support.
- It should be built on competencies. This means ascertaining the key result areas that need to be delivered and using coaching to develop these requisite competencies. Competencies may be specific to the key result areas, but could include:
  - skills
  - knowledge, qualifications and experience
  - style, attitudes and values.

Key adult learning principles

- Assessment – pre, post, and progress – it should be possible to evaluate the coached individual's progress at all the aforementioned stages. In developing learning goals, it is important to consider how the learning can and will be measured.
- The coached develops the plans, the objectives, and the evaluation process. It is crucial that the destination is theirs. Ideally they should develop the destination. If they own it, they will pursue it which will maximise change and learning.
- Clear objectives – what are we trying to achieve? In attempting to coach a staff member, it is important to set clear objectives for the coaching relationship that articulate what the coached individual is trying to achieve.
- Psychological contracts between all parties – clarity about roles. In addition to having clarity about the objectives, it is important to clarify the roles of all people involved. This may include the coach, the coached and anyone who is sponsoring the coaching (for example, the medical lead of the coached). This will avoid confusion and ensure that there is no ambiguity about the process and the anticipated outcome of the coaching process.
- Methods for enduring learning – reflection. Ensure that the coached individual reflects on their own progress. Learning occurs through insights which take place whilst in a stage of reflection. Reflection generates a feedback loop that helps the learner to learn, that is learning to learn. As a coach, you may wish to:
  - Coach people to spend say ten minutes each day in reflection. This may include considerations such as:
    - What did I do differently? What worked? What didn't?
    - What will I do tomorrow?
    - Every six months, an hour of reflection – a more insightful and reflective review – maybe with the sponsor.
    - Get them to run an event diary – reflecting on the day's key events as they are diarised.
  - Aim for doing rather than learning.
  - Use spaced practice – ensure the coached has time to apply their learning in between coaching sessions.
  - Get really specific – ensure that the goals are precise and specific.
  - Increase interference – challenge their learning by increasing the interference in order to ensure that the coached is able to perform the desired behaviours in a variety of conditions.

The two core skills of cognitive coaching are ***questioning*** and ***listening***… but it is the right forms of questioning and listening that are key.

Questioning

Questioning can be framed in several ways. Two examples are:

- Why did you do it that way?
- What would you do differently next time if you could?

The first implies judgment, no matter how carefully it is articulated. The thinking response of the coached is likely to be reinforcement of the existing conditions.

The second question will most likely cause some pondering or reflection, and this is the most productive thinking a coached can engage in for learning, stretch and growth.

A framework for coaching

A framework for coaching can include a four-step process:

- goal
- reality
- options
- what's next?

Potential questions for this framework:

Goal:

- What are you trying to achieve in this situation?
- What does success look like?
- Imagine you have achieved the best possible outcome for this challenge. You are standing at your destination, please describe it.

Reality:

- How big an issue is this? Is it in your top 5? Top 10? Top 15?
- Rate the problem out of ten, where one is no problem at all and ten is as big as possible.
- How often each day does this issue come up?
- If you rate yourself a five currently, what rating would you be happy with after you have worked on this issue?
- Rate your commitment to making this change, where one is not interested and ten is passionately committed.

Options:

- What are the options for responding to this challenge?
- Who could you get to help you?
- What resources do you have at your disposal?
- Who are the key stakeholders in putting together a good solution?
- You are standing at your destination, you have succeeded. Looking back on your journey, how did you get there?

What next?

- Now the options have been identified, rate them in terms of ease of implementation (low – medium – high) and effectiveness in helping you reach your goal (low – medium – high).
- I am going to ask you to put together an action plan for the next two weeks. We will review when next we meet.
- Let's agree on some progress assessment measures so we can be clear on how we are moving toward the destination.

Assessing coaching success

- Coaching success is often assessed through satisfaction ratings. However, the true success measure should be how much the person changed pre and post the coaching.
- Good coaches are often the ones who push learning and take the person out of his or her comfort zone.

Senior doctor, management and organisational competencies

Competencies for senior doctors, the management team and the organisation in relation to each of the senior doctor roles are listed below. These can be used in goal setting in the domains of *work achievement, professional behaviours, career progression* and *learning and development* for senior doctors, and for managerial and organisational responses to feedback received through performance development processes.

Table 1: Senior doctor roles and competencies

Senior doctor roles	Senior doctor competencies	Management team competencies	Organisational competencies
Goal setting, leadership, review, planning and evaluation	• Participate in activities that contribute to the effectiveness of your health service. • Participate in performance development and support in the health service. • Participate in health service risk management and quality improvement programs. • Work with others to monitor the effectiveness of patient care and organisational processes. • Play an active role in agreed change.	• Ensure goal congruency among individual, organisational and process goals. • Set work goals and ensure their attainment. • Link senior doctor behaviour with the goals of the organisation. • Review senior doctor performance through a formal development and support system. • Recognise when patient services review is needed to support organisational goals and processes. • Determine when team performance development and support is more appropriate than individual performance development and support. • Form teams (selection and size) which define individual roles and accountabilities.	• Ensure goal alignment across the organisation, between teams, among individuals within teams, and with organisational goals. • Set organisational goals and priorities and facilitate their attainment. • Link organisational goals to senior doctor behaviours and contributions. • Review senior doctor engagement in decision making about organisational goals. • Recognise when medical services review is needed to support organisational goals and patient outcomes. • Consult with senior doctors about medical services when services changes will impact on organisation and team more than individual senior doctors. • Use organisational change management to introduce changes to patient care services and/or integrate with existing medical services design, processes and structures.

Senior doctor roles	Senior doctor competencies	Management team competencies	Organisational competencies
Clinical expertise	• Perform the role and undertake the responsibilities of a senior doctor. • Demonstrate clinical skill and expertise. • Monitor, review and evaluate your own performance in accordance with good professional practice and organisational policies and participate in audit and peer review (see *Understanding clinical practice toolkit*).	• Support senior doctor participation in audit, peer review and other processes to monitor and improve the quality of care. • Ensure senior doctors have access to appropriate opportunities to maintain and develop clinical skills and expertise.	• Implement effective systems for credentialling and defining scope of clinical practice. • Develop and monitor compliance with policies regarding senior doctor participation in audit, peer review and other processes to monitor and improve the quality of care.
Supportive environment	• Develop effective therapeutic relationships with patients and their families. • Communicate effectively with team members and colleagues. • Work to ensure a safe working environment.	• Manage resources of unit to meet agreed quality of care goals. • Provide a safe work environment. • Eliminate barriers to performance.	• Provide resources (time, money, data, equipment and workforce) to meet organisational medical services goals. • Provide a safe work environment. • Eliminate barriers to performance.
Motivation and engagement	• Improve your satisfaction with your work. • Participate and work effectively with colleagues and other team members.	• Design meaningful position responsibilities that improve senior doctor satisfaction and ensure achievement of organisational goals. • Employ participative/ collaborative management strategies aimed at improving job satisfaction. • Use motivational theories to strengthen senior doctor commitment to the organisation.	• Construct a culture of accountable care in which senior doctors collaborate to improve illness prevention and the quality of care. • Match senior doctor credentials with organisational requirements to provide senior doctors with satisfying roles. • Ensure achievement of patient outcomes are incorporated into organisational strategies. • Employ participative decision making strategies aimed at engaging senior doctors.

Senior doctor roles	Senior doctor competencies	Management team competencies	Organisational competencies
Professionalism	• Act ethically • Comply with your legal obligations • Maintain your health and well-being • Engage with and support the organisation • Manage your career and practice • Accept opportunities to develop leadership skills • Lead and coach junior staff and medical students	• Develop career management program • Create effective recognition and reward systems • Provide relevant, immediate, frequent feedback • Recognise good performance and support performance development • Adhere to policies, procedures and regulations of federal, state, and local governments, taking into account policies and procedures of specialist medical college • Optimise job satisfaction through recruitment, selection, and placement of senior doctors • Enhance performance through coaching	• Optimise organisational performance through appropriate engagement and credentialling of senior doctors • Adhere to policies, procedures and regulations of federal, state and local governments and professional standards of specialist colleges • Create effective recognition and reward systems • Enhance senior doctor wellbeing through programs and activities • Support career management opportunities • Provide relevant and regular feedback on organisation/operation activity • Resource processes, systems and structures that enhance team contribution to organisation performance.
Health advocacy	• Advocate for your patients. • Advocate for your health service and community. • Advocate for the health of the population.	• Work with senior doctors to ensure resources are allocated appropriately in accordance with clinical need.	• Understand the needs of the community and work to develop services to meet community need.
Scholarship	• Maintain a commitment to life-long professional learning. • Undertake teaching, supervision and assessment. • Identify and accept opportunities to participate in medical research. • Contribute to the identification and promulgation of improvements in clinical practice.	• Provide opportunity for continual learning. • Enhance senior doctor wellbeing through work programs and education experiences. • Develop senior doctor knowledge, skills, and attitudes through education and training initiatives.	• Provide opportunity for ongoing professional development of senior doctors. • Monitor senior doctor knowledge, skills, and attitudes through credentialling processes, peer review/audit and systems.

Table 2: Examples of senior doctor competencies

No.	Competency	Example	Useful instruments available
1	**Goal setting, leadership review, planning and evaluation competencies (*Work achievement* domain)**		
1.1	Participate in activities that contribute to the effectiveness of your health service	**1.1a** Work with the health service and medical lead to develop an understanding of the main objectives of the health service. **1.1b** Contribute to the effective and efficient operation of your unit. **1.1c** Identify barriers that impede your work performance and communicate these to team leaders.	RACMA courses; College courses
1.2	Participate in performance development and support in the health service	**1.2a** Constructively participate in performance development and support processes. **1.2b** Work with medical lead to set goals. **1.2c** Work to achieve agreed goals.	*Partnering for performance*
1.3	Participate in health service risk management and quality improvement programs	**1.3a** Provide relevant information to clinical risk management and quality improvement programs. **1.3b** Incorporate performance results into work.	*Understanding clinical practice toolkit;* College audit processes
1.4	Work with others to monitor the effectiveness of patient care and organisational processes	**1.4a** Understand the link between the unit's and health service's objectives, so that opportunities for strategic change can be identified. **1.4b** Work with continuous improvement activities.	*Understanding clinical practice toolkit;* College audit processes
1.5	Play an active role in agreed change	**1.5a** Work with others to evaluate possible work and quality improvements. **1.5b** Encourage colleagues and other team members to be active participants in agreed change processes	

No.	Competency	Example	Useful instruments available
2	**Clinical expertise competencies (*Work achievement* domain)**		
2.1	Perform the role and undertake the responsibilities of a senior doctor	**2.1a** Understand the responsibilities and expectations of senior doctors at the health service	*Understanding clinical practice toolkit;* College audit processes
2.2	Demonstrate clinical skill and expertise	**2.2a** Consistently provide high quality care. **2.2b** Implement a management plan in consultation with the patient, family and appropriate team members. **2.2c** Use resources in an effective and ethical way.	*Understanding clinical practice toolkit;* College audit processes
2.3	Monitor, review and evaluate your own performance in accordance with good professional practice and organisational policies and participate in audit and peer review.	**2.3a** Participate in individual, team and organisational programs to monitor, review and evaluate care. **2.3b** Contribute to the improvement of quality of care and patient safety by integrating best available techniques and evidence.	*Understanding clinical practice toolkit;* College audit processes; other Victorian data collections

No.	Competency	Example	Useful instruments available
3	**Supportive environment competencies (*Professional behaviours* and *Career progression* domains)**		
3.1	Develop effective therapeutic relationships with patients and their families	**3.1a** Recognise the benefits of good communication with patients and families in improving clinical outcomes. **3.1b** Develop a common understanding about issues, problems and plans with patients and their families and convey information in an understandable and humane way. **3.1c** Respect patient confidentiality, privacy and autonomy.	College communication courses; Multi-source feedback; Patient satisfaction and complaints;
3.2	Communicate effectively with team members and colleagues	**3.2a** Elicit relevant information about patients from team members and colleagues. **3.2b** Encourage discussion with team members and colleagues about therapeutic plans. **3.2c** Be decisive and clear about management goals. **3.2d** Maintain clear and accurate records.	
3.3	Work to ensure a safe working environment	**3.3a** Ensure that those who work under your supervision and authority are free from harassment and bullying. **3.3b** Facilitate safe working hours for those who work under your supervision or authority.	OHS and HR policies; AMA Safe hours policy

No.	Competency	Example	Useful instruments available
4	**Motivation and engagement competencies (*Professional behaviours* and *Career progression* domains)**		
4.1	Improve your satisfaction with your work	**4.1a** Work with your medical lead to ensure that your responsibilities reflect your knowledge, skills and ability. **4.1b** Identify factors that will improve your work satisfaction. **4.1c** Identify opportunities for increased involvement in unit or organisational development.	
4.2	Participate and work effectively with colleagues and other team members	**4.2a** Be respectful to colleagues and other team members in your interdisciplinary team. **4.2b** Work collaboratively with other team members to provide safe and effective care for patients. **4.2c** Where appropriate provide leadership in an interdisciplinary team.	Relevant College documents

No.	Competency	Example	Useful instruments available
5	**Professionalism competencies (*Professional behaviours* and *Career progression* domains)**		
5.1	Act ethically	**5.1a** Accept your duty of care to your patients and practice safely and effectively. **5.1b** Exhibit appropriate professional behaviours. **5.1c** Respect professional and personal boundaries. **5.1d** Recognise and manage ethical issues and potential conflicts of interest.	AMC Good Medical Practice; AMA Code of practice
5.2	Comply with your legal obligations	**5.2a** Understand and comply with legislative and regulatory requirements.	National registration legislation; AMC Good Medical Practice
5.3	Maintain your health and well-being	**5.3a** Balance your personal and professional responsibilities to ensure your own health and well-being. **5.3b** Seek independent, objective advice when you need medical care.	Victorian Doctors health program
5.4	Provide guidance and assistance to your colleagues when needed	**5.4a** Encourage your colleagues to seek appropriate help if you believe they are ill or impaired.	Victorian Doctors health program
5.5	Engage with and support the organisation	**5.5a** Recognise your key role in assisting the organisation to achieve its objectives and in influencing other staff **5.5b** Familiarise yourself with the organisation's vision, mission, strategies and goals **5.5c** Contribute positively to organisational strategic activities **5.5d** Be respectful to the organisation and its medical leads	NHS Institute for Innovation and Improvement – Engaging doctors; Reinersten et al, 2007 *Engaging physicians in a shared quality agenda*, www.IHI.org

No.	Competency	Example	Useful instruments available
5	**Professionalism competencies (*Professional behaviours* and *Career progression* domains)**		
5.6	Manage your career and practice	**5.6a** Work with your medical lead to establish your career progression in the health service. **5.6b** Identify opportunities for your career development. **5.6c** Identify opportunities to build your practice to the benefit of you and the health service.	For example, Early specialist career – establish and consolidate practice; additional academic and research activity. Mid-career – pursue leadership opportunities. Later career – consider a change in mix of work.
5.7	Accept opportunities to develop leadership skills	**5.7a** Recognise and support the importance of teamwork. **5.7b** Support your colleagues and juniors in achieving team goals. **5.7c** Support juniors to achieve individual performance objectives and provide informed and timely feedback to your juniors.	NHS Institute for Innovation and Improvement – Engaging doctors
5.8	Lead and coach junior staff and medical students	**5.8a** Act as role model in clinical and non-clinical aspects of work. **5.8b** Provide leadership in critical situations. **5.8c** Provide constructive criticism to team members and medical students. **5.8d** Give credit for work well done.	Postgraduate Medical Council of Victoria; Train the trainers programs

No.	Competency	Example	Useful instruments available
6	**Health advocate competencies (*Professional behaviours* and *Career progression* domains)**		
6.1	Advocate for your patients	**6.1a** Seek the best possible care options for your patients. **6.1b** Support patients if they seek alternative opinions.	AMA Code of practice; College codes of practice
6.2	Advocate for your health service and community	**6.2a** Be well-informed about the health needs of your community and the opportunity for service development. **6.2b** Understand barriers to health care for your community. **6.2c** Understand mechanisms available to influence on behalf of your health service and community.	AMA Code of practice; College codes of practice; Consumers health forum
6.3	Advocate for the health of the population	**6.3a** Understand the role of the medical profession in advocating for health and patient safety. **6.3b** Understand the importance of altruism, social justice, autonomy and integrity in advocating for the health of the population.	AMA Code of practice; College codes of practice

No.	Competency	Example	Useful instruments available
7	**Scholarship competencies (*Learning and development* domain)**		
7.1	Maintain a commitment to life-long professional learning	**7.1a** Understand the principles of maintaining professional competence. **7.1b** Undertake continuing education. **7.1c** Document continuing learning program.	Specialist medical college
7.2	Undertake teaching, supervision and assessment	**7.2a** Develop competencies and skills as a teacher. **7.2b** Determine the learning needs of prospective medical students and junior doctors. **7.2c** Provide appropriate supervision to medical students or junior doctors. **7.2d** Provide worthwhile feedback.	Postgraduate Medical Council of Victoria; Train the trainers programs
7.3	Identify and accept opportunities to participate in medical research	**7.3a** Understand the legislation and guidelines that governs medical research in Victoria. **7.3b** Submit grant applications. **7.3c** Comply with approved protocols for research. **7.3d** Submit manuscripts to peer-reviewed journals. **7.3e** Submit presentations to conference organisers.	NHMRC research guidelines
7.4	Contribute to the identification and promulgation of improvements in clinical practice	**7.4a** Accept opportunities to work alone or with colleagues to identify opportunities for improvements in clinical practice. **7.4b** Integrate new learning into your practice. **7.4c** Identify opportunities to disseminate worthwhile findings to others.	Specialist medical colleges

Table 3: Examples of management team competencies

No.	Competency	Example
1	**Goal setting, leadership, review, planning and evaluation competencies**	
1.1	Ensure goal congruency among individual, organisational and process goals.	**1.1a** Integrate senior doctor motives, drives, and needs with team and organisational goals. **1.1b** Link team and organisational goals with individual performance. **1.1c** Create clear picture of performance expectations. **1.1d** Communicate organisational/team goals to gain senior doctor commitment.
1.2	Set work goals and ensure their attainment.	**1.2a** Motivate senior doctors through the use of team goals. **1.2b** Teach senior doctors how to set individual performance goals. **1.2c** Involve senior doctors and team in goal-setting process. **1.2d** Integrate work goals into human resource management practice. **1.2e** Eliminate barriers to work goal attainment.
1.3	Link senior doctor behaviour with goals of the organisation	**1.3a** Evaluate individual, work process, and organisational results. **1.3b** Determine if role and scope of clinical practice maximises outcomes. **1.3c** Assess senior doctor/team knowledge, skills and attitudes.
1.4	Review senior doctor performance through a formal development and support system.	**1.4a** Review senior doctor work performance. **1.4b** Provide appropriate performance intervention to support improvement. **1.4c** Incorporate performance results into a continuous improvement program **1.4d** Ensure fairness and objectivity in assessments and advice.
1.5	Recognise when patient services review is needed to support organisational goals and processes.	**1.5a** Determine whether role performance can benefit from redesign. **1.5b** Assess need and/or feasibility of service role. **1.5c** Consider the effects of role redesign on patient care and the organisation. **1.5d** Align senior doctor credentialling with process requirements and organisational goals.
1.6	Determine when team performance development and support is more appropriate than individual performance development and support.	**1.6a** Assess organisational climate. **1.6b** Evaluate team processes so as to accommodate individual senior doctors. **1.6c** Determine the feasibility of creating changes to the team to accommodate organisational needs. **1.6d** Determine whether individuals can be managed and supported.
1.7	Form teams (selection and size) which define individual roles and accountabilities	**1.7a** Apply group dynamic and interpersonal processes to manage work teams. **1.7b** Provide a supportive organisational context. **1.7c** Monitor the design of the group. **1.7d** Provide training, technical consultation, and role clarification.

No.	Competency	Example
2	**Clinical expertise competencies**	
2.1	Support senior doctor participation in audit, peer review and other processes to monitor and improve the quality of care.	**2.1a** Develop a positive environment for participation in audit, peer review and clinical practice improvement. **2.1b** Work with health service to provide administrative support for audit and other quality of care programs. **2.1c** Support senior doctors to improve performance if problems are identified.
2.2	Ensure senior doctors have access to appropriate opportunities to maintain and develop clinical skills and expertise.	**2.2a** Work with senior doctors to identify areas of clinical practice for future development. **2.2b** Work with health service to ensure resources are available for senior doctors to maintain and develop clinical skills and expertise.
3	**Supportive environment competencies**	
3.1	Manager of unit/ department to meet agreed quality of care goals.	**3.1a** Determine which resources optimise performance. **3.1b** Manage resources within limits imposed by organisation.
3.2	Provide a safe work environment.	**3.2a** Design work environment to minimise risk of injury. **3.2b** Apply ergonomic principles to the work area. **3.2c** Evaluate the cost of workplace injury on quality and productivity.
3.3	Eliminate barriers to performance.	**3.3a** Remove performance constraints in the workplace. **3.3b** Provide supportive organisational context **3.3c** Evaluate organisational systems (technology, personnel, and control) effect on job performance.

No.	Competency	Example
4	**Motivation and engagement competencies**	
4.1	Design meaningful position responsibilities and scope of practice that improve senior doctor satisfaction and ensure achievement of organisational goals.	**4.1a** Design position responsibilities and scope of practice that ensure the best fit between the senior doctor's knowledge, skills and abilities and their need for autonomy, feedback, personal growth and meaningful work. **4.1b** Design service responsibilities to fit individual need for growth.
4.2	Employ participative/ collaborative management strategies aimed at improving job satisfaction.	**4.2a** Provide senior doctors with opportunities to participate in the medical lead process. **4.2b** Gain commitment throughout the organisation for senior doctor involvement. **4.2c** Align participative management with human resource policies.
4.3	Use motivational theories to strengthen senior doctor commitment to the organisation.	**4.3a** Select the appropriate method to motivate senior doctors. **4.3b** Integrate motivational theory into daily performance management. **4.3c** Acknowledge effect of workforce on senior doctor commitment to the organisation.
5	**Professionalism competencies**	
5.1	Develop career management program.	**5.1a** Assist senior doctors to identify skills, interests, and motivations for career growth. **5.1b** Prepare senior doctors for job of the future with organisation's services development needs. **5.1c** Implement career progression support programs. **5.1d** Solicit senior doctor input into his or her career planning process **5.1e** Identify and communicate opportunities and standards for promotion.
5.2	Create effective recognition and reward systems.	**5.2a** Identify incentives and rewards that have value for senior doctors. **5.2b** Link effort, performance, and valued rewards. **5.2c** Administer timely recognition and reward system fairly and equitably. **5.2d** Ensure that compensation program provides the best fit for the organisation, team and senior doctor goals.
5.3	Provide relevant, immediate, frequent feedback.	**5.3a** Assess senior doctor performance against goals and patient outcomes. **5.3b** Communicate to senior doctors about their level of performance. **5.3c** Provide climate for constructive communication.

No.	Competency	Example
5	**Professionalism competencies**	
5.4	Recognise good performance and support performance development.	**5.4a** Implement mechanisms that can identify good performance.
5.5	Adhere to policies, procedures and regulations of federal, state, and local governments, taking into account policies and procedures of specialist medical college.	**5.5a** Interpret government policies as they relate to the workplace and facilitate/ ensure compliance. **5.5b** Understand laws that affect the role and services delivery and ensures senior doctor/team compliance. **5.5c** Link policies and procedures with job activities and communicates to senior doctors/others. **5.5d** Evaluate the effect of policies and procedures on performance and communicate barriers to team.
5.6	Optimise job satisfaction through recruitment, selection, and placement of senior doctors.	**5.6a** Develop senior doctor commitment through recruitment practices. **5.6b** Choose senior doctors with values congruent with the organisation. **5.6c** Use selection and placement strategies to identify and develop future leaders. **5.6d** Place senior doctors based on fit between role and senior doctor competencies.
5.7	Enhance performance through coaching.	**5.7a** Develop and implement a process for coaching senior doctors. **5.7b** Guide (stewardship) senior doctors and team efforts to improve performance. **5.7c** Recognise performance improvement in others.

No.	Competency	Example
6	**Health advocate competencies**	
6.1	Work with senior doctors to ensure resources are allocated appropriately in accordance with clinical need.	**6.1a** Work with senior doctors to identify key health priorities for the local community and population catchment.
7	**Scholarship competencies**	
7.1	Provide an opportunity for continual learning.	**7.1a** Develop capacity of senior doctors to contribute to team. **7.2b** Provide an environment conducive to ongoing learning and professionalism.
7.2	Enhance senior doctor well-being through work programs and education experiences.	**7.2a** Recognise and respond to personal needs of senior doctors. **7.2b** Accommodate senior doctor work and lifestyle differences. **7.2c** Redesign role and work to reduce unnecessary work and workplace stress. **7.2d** Offer programs that address the quality of senior doctor work life.
7.3	Develop senior doctor knowledge, skills, and attitudes through education and training initiatives.	**7.3a** Identify competencies for successful role performance. **7.3b** Identify critical training needs. **7.3c** Develop and implement training interventions. **7.3d** Ensure transfer of training. **7.3e** Evaluate effectiveness of training.

Table 4: Examples of organisational competencies

No.	Competency	Example
1	**Goal setting, leadership, review, planning and evaluation competencies**	
1.1	Ensure goal alignment across the organisation, between teams, among individuals within teams, and with organisational goals.	**1.1a** Make the hospital an accountable-care organisation so that the patient is central to operations. **1.1b** Integrate organisational goals with divisional/unit responsibilities and accountabilities. **1.1c** Link organisational performance with divisional and individual motivation and goals.
1.2	Set organisational goals and priorities and facilitate their attainment.	**1.2a** Motivate senior doctors through the use of work goals. **1.2b** Involve senior doctors in health service goal-setting.
1.3	Link organisational goals to senior doctor behaviours and contributions.	**1.3a** Evaluate organisational results. **1.3b** Monitor medical services performance. **1.3c** Discuss development of service plans with medical services.
1.4	Review senior doctor engagement in decision-making about organisational goals.	**1.4a** Provide appropriate operational performance reports. **1.4b** Incorporate operational performance reports into service improvement programs. **1.4c** Seek senior doctor satisfaction with management and medical services supports, processes and engagement.
1.5	Recognise when medical services review is needed to support organisational goals and patient outcomes.	**1.5a** Determine whether medical services can benefit from review and redesign and/or re-prioritising. **1.5b** Consider the effects of patient care services redesign on medical services and the organisation. **1.5c** Align medical services with patient care requirements and organisational goals.
1.6	Consult with senior doctors about medical services when service changes impact on organisation and team more than individual doctors.	**1.6a** Evaluate organisational requirements to accommodate changes to medical services. **1.6b** Determine whether work groups can be managed and supported.
1.7	Use organisational change management to introduce changes to patient care services and/or integrate with existing medical services design, processes and structures.	**1.7a** Apply best practice change management and interpersonal process principles to the introduction of changes of patient care services. **1.7b** Provide a supportive organisational context. **1.7c** Monitor patient care services change in consultation with senior doctors and others as appropriate. **1.7d** Receive technical advice from senior doctors, and use appropriate human resources processes to support implementation of change.

No.	Competency	Example
2	**Clinical expertise competencies**	
2.1	Implement effective systems for credentialling and defining scope of clinical practice	**2.1a** Establish credentialling and scope of clinical practice programs which are compliant with Department of Health requirements.
2.2	Develop and monitor compliance with policies regarding senior doctor participation in audit, peer review and other processes to monitor and improve quality of care.	**2.2a** Develop policies about participation in peer review, audit and other quality programs. **2.2b** Provide resources to enable senior doctors to participate in effective and timely quality activities. **2.2c** Provide resources so that the *Understanding clinical practice toolkit* can be effectively applied in health service.
3	**Supporting environment competencies**	
3.1	Provide resources (time, money, data, equipment and workforce) to meet organisational medical services goals.	**3.1a** Determine which resources optimise performance. **3.1b** Manage resources within limits imposed by organisation governance and health system policy imperatives. **3.1c** Provide nursing, clinical and non-clinical support services to enable medical services to deliver high standard of medical services.
3.2	Provide a safe work environment.	**3.2a** Design work environment to minimise risk of injury and enhance delivery of patient care services.
3.3	Eliminate barriers to performance.	

No.	Competency	Example
4	**Motivation and engagement competencies**	
4.1	Construct a culture of accountable care in which senior doctors collaborate to improve illness prevention and the quality of care.	**4.1a** Select the appropriate incentives to motivate senior doctors. **4.1b** Integrate a patient focus into regular organisation and divisional performance discussions. **4.1c** Acknowledge the importance of clinical engagement on senior doctor commitment to the organisation.
4.2	Match senior doctor credentials with organisational requirements to provide senior doctors satisfying roles	**4.2a** Implement credentialling and scope of clinical practice systems that ensure the best fit between senior doctor competencies and their need for professional autonomy, feedback and professional development. **4.2b** Support opportunities for professional development of senior doctors.
4.3	Ensure achievement of patient outcomes are incorporated into organisational strategies	
4.4	Employ participative decision making strategies aimed at engaging senior doctors.	**4.4a** Support structures and processes to strengthen senior doctor involvement and collaboration in organisational decision forming process. **4.4b** Gain commitment throughout the health service for senior doctor involvement.

No.	Competency	Example
5	**Professionalism competencies**	
5.1	Optimise organisational performance through appropriate engagement and credentialling of senior doctors.	**5.1a** Develop senior doctor commitment through recruitment practices. **5.1b** Choose senior doctors with values consistent with those of the organisation. **5.1c** Credential senior doctors based on fit with the organisation's needs and best patient outcomes.
5.2	Create effective recognition and reward systems.	**5.2a** Design incentives and rewards that have value for all executive medical leads and senior doctors. **5.2b** Implement recognition and reward systems that are transparent and fair. **5.2c** Ensure the reward program fits both the organisation's and senior doctors' goals. **5.2d** Build environment of mutual trust.
5.3	Enhance senior doctor wellbeing through programs and activities.	**5.3a** Recognise and respond to personal needs of senior doctors. **5.3b** Create work environment that addresses the quality of senior doctor work life and workplace stress.
5.4	Support career management opportunities.	**5.4a** Be transparent about organisation's future directions and facilitate senior doctor career development and progression. **5.4b** Identify and communicate opportunities and standards for promotion
5.5	Provide relevant and regular feedback on organisation/ operations activity.	**5.5a** Relate divisional performance to organisational performance. **5.5b** Discuss organisational performance with senior doctors. **5.5c** Provide environment for safe and constructive communication. **5.5d** Expect leaders/medical leads to engage with senior doctors in discussions about organisation and patient outcomes. **5.5e** Seek feedback from senior doctors about organisation performance constraints/barriers.
5.6	Resource processes, systems and structures that enhance team contribution to organisation performance.	**5.6a** Resource a process for mentoring and peer review. **5.6b** Implement a framework for senior doctors to strengthen performance. **5.6c** Recognise education and training for performance improvement.

No.	Competency	Example
6	**Health advocate competencies**	
6.1	Understand the needs of the community and work to develop services to meet community need.	**6.1a** Establish key health planning and development priorities for the local community and population catchment.
7	**Scholarship competencies**	
7.1	Provide opportunity for ongoing professional development of senior doctors.	**7.1a** Provide maintenance of competency programs for senior doctors. **7.2b** Support opportunities for senior doctor learning, for example, peer review, professional, college training and retraining programs (CPD).
7.2	Monitor senior doctor knowledge, skills and attitudes through credentialling processes, peer review/audit and systems.	**7.2a** Identify senior doctor competencies for successful performance. **7.2b** Provide access to critical training needs. **7.2c** Liaise with senior doctor and college to support training interventions. **7.2d** Monitor senior doctor engagement in college professional development programs. **7.2e** Provide support for introduction and use of *Understanding clinical practice toolkit*. **7.2f** Respond appropriately to patient complaints and incidents in consultation with Medical Advisory Committee. **7.2g** Respect college/registration boards responsibilities for stewardship of professional standards and performance.

Understanding clinical practice toolkit

Contents

Formal peer review

Definition

Formal peer review is the process by which individuals of the same profession, experience and working in similar organisational settings, critically assess their colleague(s) performance, in order to reinforce areas of strength and quality in patient care, and to identify areas for development or improvement.

Background

Peer review involves some form of performance assessment or judgment on a senior doctor's performance, where a number of elements of clinical practice are assessed including:

- clinical expertise and practice
- communication
- scholarship
- professionalism.

Peer review in various forms has been used in medical practice since the inception of individual case review in the 1880s. In recent years changes to credentialling and appointment processes, along with concerns about the quality and safety of health care have resulted in a renewed interest in the use of peer review as a technique for assessing and monitoring clinical care.

There is a growing evidence base for peer review as an assessment and quality improvement process, both in health care and in related industries.[1]

In health care, peer review has been shown to be effective in improving professional practice through improving knowledge and in facilitating positive changes in practice amongst senior medical practitioners in several disciplines. In addition, peer review processes are associated with improved motivation and engagement. Improved patient satisfaction and outcomes may be a benefit of this process.

Peer review supports 'achieving and delivering optimal quality of care… [through] continual self-examination by the profession, particularly with regard to technical, interpretive, and communicative skills' (Alpert & Hillman 2004, p.127). The peer review process is thus steeped in concepts of supporting clinical practice and building on excellence.

Formal peer review provides professional bodies and health services with a method for assessing or judging the performance of senior doctors, particularly in areas which are difficult to assess, such as communication, interprofessionalism, teamwork and relationship building with patients. Peer review is intended to provide individuals with an insight into the way others perceive their performance. In doing so, peer review offers participants an opportunity to reflect on their own performance.

[1] The literature review for *Peer review* is available at www.health.vic.gov.au/clinicalengagement.

Peer review may enable organisations to identify senior doctors who are at risk of underperformance or who are underperforming and may require assistance. The process should assist senior doctors with performance concerns through the formulation and implementation of agreed remedial strategies.

The peer review process generally includes one or more of the following:

- identification of the doctor's strengths and weaknesses by the doctor and their peers
- a comparison of these strengths and weaknesses with an 'average' colleague in their peer group
- identification of areas which require development
- creation of an agreed development plan to address these areas.

Peer review is thus an effective method:

- for understanding clinical performance within a broader organisational context
- for comparing self assessment of otherwise difficult to assess competencies
- to assist in the identification of medical practitioners experiencing difficulties
- to aid in changes in practice behaviour, such as uptake of guidelines.

Purpose

Peer review is an important tool for understanding and supporting the improvement of clinical practice. Formal peer review should inform organisational performance development and support processes, and in doing so contribute to clinical governance responsibilities. In *Partnering for performance* formal peer review has two distinct purposes:

- it is a key element of the credentialling/re-credentialling process
- it should be considered the key forum or activity for understanding and judging issues of an individual senior doctor's clinical performance where significant concerns about an individual's performance have been raised (that were not able to be managed at the local (for example, unit/department) level).

Formal peer review in this context is not referring to informal peer based review (for example, as part of a unit or service based case discussion or routine performance conversation).

Formal peer review processes, when well designed for their intended purpose, properly resourced and clinically led, have high level clinical acceptance. They may provide an important mechanism for understanding clinical performance at the level of the individual senior doctor, and thus provide an important quality governance mechanism to support credentialling and scope of practice processes, and secondly, the assessment and management of possible senior doctor underperformance.

This guide to peer review should be used in conjunction with the Australian Commission on Safety and Quality in Healthcare *Peer review guide*[2].

[2] This document is due for release in 2010.

How to undertake peer review for the purpose of understanding and managing potential underperformance

The medical director (or equivalent) has responsibility for initiating and leading a formal peer review process. This should be managed within the context of the organisation's credentialling and scope of practice processes.

Successful formal peer review requires an open and positive organisational culture which emphasises excellent clinical care.

1. The process should be framed and promoted internally as an activity designed to support clinical practice. In particular:
    - clear terms of reference for the process should be provided to all relevant parties
    - the individual being reviewed must be involved in the development of the assessment process
    - the individual being reviewed must be offered the option of external support (for example, colleague/legal practitioner) for the duration of the process
    - the process must operate on a 'no surprises' basis – the doctor being reviewed should be aware of all processes and activities undertaken
    - where an individual refuses to participate in an appropriately structured and constituted peer review process undertaken for the consideration of apparent underperformance, the medical board should be notified.
2. To assess an individual's clinical practice, a standardised, tool-driven (questionnaire, case analysis) assessment should be used. Review processes may also include: significant event analysis; direct observation (including video-taping of consultations); record, case note or chart review; objective structured clinical examination; practice visits; and patient feedback.
3. Simple measurement scales which are suitable for the intended purpose should be used. The individual being reviewed must be involved in the development of these scales.
4. Where possible and where appropriate, senior doctor level clinical data such as number of complications and mortality data, should be collected prior to the peer review to assist with peer comparison. The doctor under review must have access to this data. Other relevant clinical elements (for example, college continuing professional development (CPD) processes) should also be considered. Care should be taken in interpreting clinical data, giving consideration to the issues and cautionary notes raised elsewhere in this toolkit.
5. Participants must be appropriately trained in the peer review process and the provision and receipt of feedback.
6. Where possible, a number of reviewers should be involved in the process. In some settings it may be reasonable to use peers from within the workplace of the senior doctor undergoing review. Where possible, senior doctors reviewing underperformance should be independent of both the senior doctor being reviewed and the senior doctor's workplace.

7. The peer review process makes a finding regarding the presence or absence of underperformance. When underperformance is present, the reviewers must identify the areas of underperformance and provide guidance regarding the possibility of remediation.
8. A formal written report of the outcomes of the peer review process should be provided to the organisation's credentialling and scope of practice committee. The committee should:
    - meet promptly to decide a way forward which may include recommendations about practice development, review of scope of practice or referral to the medical board
    - provide prompt, formal written feedback to the doctor undergoing formal peer review. This feedback must include the full findings of the peer review process, the conclusions of the process, and recommendations. This feedback should be incorporated into the senior doctor's performance development process and recorded in the doctor's personnel file.
9. The organisation should also ensure that:
    - the process is properly resourced and appropriate administrative support is available
    - all participants sign a confidentiality agreement prior to commencing the peer review.

Critical risks to consider in using the tool

The processes of formal peer review, in order to be effective as an assessment process (and be able to withstand, for example, legal challenge), must be reliable, valid, feasible and have an educational impact.

A number of barriers to the peer review process have been identified, these include:

- lack of clarity on behalf of the organisation and participants regarding the purpose of the process
- lack of standardised processes
- lack of meaningful clinical level data for peer comparison
- limited reliability of assessment procedures
- participants having limited time to commit to the process
- lack of experience and training in review procedures
- fear of criticism and negative evaluations from colleagues
- negative attitudes of doctors and peers towards the peer review process
- an antagonistic professional or organisational culture
- lack of engagement by and with senior medical staff.

Every effort should be made to ensure that the organisation's approach to formal peer review is:

- non punitive and focuses on enhancing the relationship between senior doctor and organisation
- properly structured to ensure consistency and reproducibility through the use of a standardised approach which is relevant and acceptable to senior doctors.

Both senior doctor and organisation must be willing to collaborate and cooperate around managing the outcomes of the peer review process. The process will have no value if organisation and/or senior doctor are unable or unwilling to deliver on identified issues.

Failure to adopt a consistent, properly structured, transparent approach designed to engage both organisation and the senior doctor undergoing review renders this process liable to misinterpretation and potentially to legal challenge.

Victorian approach to peer review for the purpose of credentialling and defining scope of practice

The *Credentialling and defining the scope of clinical practice for medical practitioners in Victorian health services* policy (Department of Human Services 2007) recognises that peer assessment and the willingness of individuals to comment on their own skills and the skills of others are fundamental to successful processes of credentialling and defining the scope of clinical practice. Peer review should be a key element of re-credentialling (through the credentialling committee) of all senior doctors appointed to Victorian public hospitals. Similar principles to those outlined above should apply:

1. The process should be framed and promoted internally as an activity designed to support excellent clinical practice.
2. Standardised assessment processes including relevant clinical data and simple measurement scales which are suitable for the intended purpose should be used. The individual being reviewed must be aware of these measures.
3. Where possible, a number of reviewers should be involved in the process. In most settings it would be reasonable to use peers from within the workplace of the senior doctor undergoing review.
4. The peer review process makes a finding regarding the appropriateness of re-credentialling and recommendations regarding scope of practice.
5. The organisation should also ensure that the process is properly resourced and appropriate administrative support is available.

Victorian approach to peer review for the purpose of understanding and managing potential underperformance

Senior doctors appointed to Victorian public hospitals should participate in a formal peer review process if there are concerns about the doctor's clinical performance sufficient to prompt an organisation level inquiry.

Formal peer review processes should NOT be used to initially investigate clinical performance issues. Where possible, performance issues should be initially investigated and managed by the doctor's medical lead (medical director, unit head or equivalent) as outlined in *Partnering for performance*.

Similarly, formal peer review processes should not be required for routine monitoring of clinical performance at the clinical service/unit/department level. There is an expectation that there is peer input and informal peer review in all clinical performance discussions at the local level. This input should occur during the use of the tools that organisations have to monitor clinical performance as outlined in this toolkit.

Adverse occurrence screening/ Targeted case note review

Definition

The review of selected or targeted medical records by medical colleagues using screening criteria which may be associated with care related adverse events.

Background

Adverse occurrence screening (AOS)/targeted case note review (TCNR) seeks to identify underlying problems with care delivery which might provide opportunities for clinical improvement.

Although based on the broader Medical Management Analysis system, Limited adverse occurrence screening (LAOS) is uniquely Victorian in origin, developed at Wimmera Health Care Group in 1989 by Professor Alan Wolff and colleagues.

LAOS was developed in recognition that adverse outcomes and medical care errors amongst inpatients may not be detected by traditional methods such as incident reporting (underreporting is common) or ad hoc selective case note review (subject to inconsistency and potential bias).

Elements of AOS/TCNR are already being undertaken in many hospitals (for example, review of deaths, patients transferred to ICU) however the review process is often inconsistent and ad hoc. AOS/TCNR standardises case note review using a peer based system that is consistent and reproducible.

The reported immediacy and flexibility of AOS/TCNR as a review process, coupled with the general strength of occurrence screening as a method of identifying adverse events, would suggest that it has value for clinical practice improvement in a range of clinical settings.[3]

Amongst its strengths are:

- its ability to engage senior doctors
- the automatic review of the care provided by all doctors
- the clear link between findings and individual, team and service improvement strategies.

AOS/TCNR involves three key steps:

1. Screening of medical records for key patient outcome criteria. The criteria are predetermined by the doctors whose care is being reviewed. Examples of screening criteria include:
   - unexpected patient death
   - cardiac arrest/medical emergency team (MET) calls
   - patient returning to theatre within seven days
   - transfer of patient from a ward to intensive care unit.

   This screening is conducted by medical records/health information administrators, support staff, senior doctors, or as has been trialled more recently, by computers using administrative data sets.

[3] The literature review for *AOS/TCNR* is available at www.health.vic.gov.au/clinicalengagement

2. These medical records are then reviewed by experienced, trained, senior doctors (usually peers who have not been involved in the care of the patient). This is conducted in a structured and reproducible fashion seeking evidence of likelihood, type, severity and preventability of errors. Questions asked at this stage might include:
    - Did an incident/adverse event occur?
    - What injury resulted?
    - Was the situation preventable?
    - What lessons can be learned?
3. This information is then used to develop quality improvement strategies and programs, including through:
    - broader discussion of the case in a peer forum (for example, morbidity and mortality meeting)
    - involvement of other organisational elements in establishing a formal improvement strategy.

One limitation of AOS/TCNR is that it is based on retrospective case note review. This can be addressed by ensuring rapid screening following patient discharge and allowing reporting of key incidents by individual doctors, thus enabling a prompt and targeted review. In addition, the use of typed discharge summaries and in future, electronic medical records should assist in minimising delays and screening issues.

Purpose

AOS/TCNR can be used to identify cases for subsequent discussion or review (for example, at a morbidity and mortality meeting). In doing so, it has the potential to reduce the uncertainty and inconsistency inherent in selecting cases for discussion in such a forum, and thereby enhances the understanding of any underlying clinical practice issues.

AOS/TCNR may be combined with other clinical measures including clinical audit to allow a broader picture of an individual's clinical performance. The benefits from this process are maximised when clinical performance is monitored over time.

AOS/TCNR activities may also prompt escalation to formal peer review processes.

If structured correctly, properly resourced, and seen as part of a system level approach to understanding adverse outcomes and clinical practice, AOS/TCNR can contribute to the development of an integrated understanding of clinical practice at the level of the individual senior doctor.

How to undertake AOS/TCNR

Each hospital should conduct its AOS/TCNR at the most appropriate level for that organisation. For example, at the hospital level for a small hospital with limited local specialist input, or for larger hospitals, at the level of a clinical service, unit or department.

The tool has been applied at the level of specific services (for example, internal medicine service covering all physician activities) or across specialty hospital settings (for example, paediatric services). Units/departments should choose screening criteria appropriate to their clinical needs to ensure they have specific value in terms of understanding clinical practice at a local level (for example, anastamotic leaks post colorectal surgery, development of medication side effects, post partum haemorrhage).

To enable proper use and maximum benefits, AOS/TCNR requires:

- an open and positive organisational culture, which focuses on excellent clinical care
- the process to be led by a senior doctor who has an ability to engage with clinical colleagues and to facilitate change at the patient care level
- an awareness by senior doctors that their records will be screened as part of this process
- support from health information staff to screen records
- training for the team of reviewers to provide peer input into the process
- senior doctors willing and able to participate as case reviewers
- allocated (funded) time for reviewers
- a clear and transparent approach to case note review – this should be standardised and ideally electronic
- properly structured meetings to review and consider recommendations from the AOS/TCNR process/discuss cases (see *Mortality and morbidity review tool*)
- clinical governance structures and processes which have an ability to influence change and to drive improvement (including processes to report findings and implemented strategies to all relevant groups).

To establish and maintain a AOS/TCNR program:

- clearly outline to senior doctors how the program will assist them in improving the delivery of patient care
- define the program's medical leadership (for example, unit/department specific)
- clearly identify communication channels and how the program will report through organisational clinical governance processes and to senior medical staff
- agree on the scope of the program (in larger hospitals this should be at the unit/department level to ensure applicability and acceptance – individual departments or units may modify screening criteria to suit local practice and patient factors)

- agree on participants:
  - for example, three or more senior doctors per department/unit (depends on local needs)
  - junior medical staff may also be involved but decision making responsibilities should lie with the senior doctors
  - senior nursing and other clinical staff may also be involved to enable multidisciplinary approaches to understanding clinical practice, although the participants should be predominantly medical
  - reviewers should not review the records of their own patients
- agree on screening criteria (this should be the responsibility of the relevant medical lead and should reflect the clinical services provided by the department/unit)
- the following screening criteria should be included in all AOS/TCNR programs:
  - patient death which is unexpected by the clinical team
  - all medical emergency team (MET) calls or code blue/cardiac arrests
  - transfer of a patient from a ward to intensive care unit
  - for surgical services – unexpected return to theatre
  - any medical record referred by a senior doctor or other clinician for review
- inpatient cases should be screened within one month of discharge and formally reviewed within two months of discharge (local key performance indicators (KPIs) should be developed to ensure ongoing monitoring of the timeliness of the AOS/TCNR process)
- establish a consistent approach to the management of reported data – data should be recorded electronically and reported back to senior doctors on a three monthly basis (as a minimum)
- ensure adequate support for this process.

In organisations undertaking AOS/TCNR at unit or department level, resources such as health information management staff, administrative support and clinical quality staff may be shared across a number of AOS/TCNR programs.

It is imperative that information derived from the AOS/TCNR program be aggregated into a format which allows regular review and action (where needed) through the organisation's usual clinical governance processes.

Critical risks to consider in using the tool

Most critiques relate to the issues of validity and sensitivity of indicators. Simplifying the definitions of the indicators should increase consistency (as has been found in the roll out of AOS/TCNR in a number of Victorian regional general practice based hospitals).

Whilst AOS/TCNR is intended to review records with a high probability of containing adverse events, it will by definition miss errors which are not predictable or are hidden. However, AOS/TCNR is not intended to capture all adverse events or issues of concern, but rather to sit alongside other existing programs such as incident reporting. In doing so, AOS/TCNR can contribute to developing a picture of clinical practice at both the system and individual level.

Victorian approach

AOS (as the LAOS program) is currently in place in some small rural hospitals assisted by local Divisions of General Practice.

The program is outlined at:
http://www.health.vic.gov.au/clinrisk/publications/laosreview.htm

Specialist and general hospitals in regional Victoria and metropolitan Melbourne have adapted elements of the LAOS program.

All hospitals should be using AOS/TCNR at an appropriate level (either whole of hospital, clinical service, department or unit). When combined with other clinical tools, AOS/TCNR may be able to provide significant insight into an individual's clinical practice, particularly where underperformance is occurring.

Examples of AOS/TCNR forms are available at:
www.health.vic.gov.au/clinicalengagement

Example Adverse occurrence screening /Targeted case note review form

< Health Service >
< Unit/Department/Service >

A. Health information manager:

Hospital Code:	**Doctor Code:**
Patient UR Number:	**Date of birth:**
Admission Date:	**Sex:** ☐ M ☐ F
Discharge Date:	**HIM initials:**

Screening criteria (Tick all criteria met during this admission)

☐ Patient death
☐ Unplanned return to theatre within 7 days
☐ Unplanned re-admission within 28 days of discharge
☐ Transfer to another health service
☐ Patient length of stay greater than 35 days
☐ Any record which has been recommended by a doctor or other health professional for review *(specify reason)*

B. Project officer:

Reviewer code:	**Date record sent for review:**
Date returned:	**Action/Comments:**

C. Reviewer:

Please review the medical record to identify adverse patient events or education and/or quality improvement opportunities.

To be considered an ***adverse event*** the following criteria shall be met:

An unintended injury, or harm that

1. Resulted in temporary or permanent disability, hospitalisation, including increased length of stay and/or financial loss to the patient, and
2. Was caused by health care management (either at an individual or systems level) rather than the underlying disease process.

Please tick *Yes* or *No* to the following two statements:	**Yes**	**No**
This record contains a possible adverse event.	☐	☐
There is no adverse event but possible education or quality improvement opportunity	☐	☐

If you have ticked **No** to both statements please proceed to section E
Otherwise please continue below and complete the whole form

Consequence – please tick the appropriate level of actual OR potential consequence

☐ **1. Insignificant** – No injury, increased level of care or length of stay
☐ **2. Minor** – Increased level of care including review and evaluation, additional investigations or referral to another clinician
☐ **3. Moderate** – Permanent reduction in bodily functioning unrelated to natural course of illness or differing from the expected outcome of management. Also includes increased length of stay or surgical intervention as a result of the event.
☐ **4. Major** – Major permanent loss of function or disfigurement as a result of the event unrelated to natural course of illness and differing from the expected outcome of management.
☐ **5. Extreme** – Unexpected death unrelated to natural course of illness or differing from the expected outcome of patient management. Also includes procedures involving wrong patient or body part, suicide during admission, retained instruments, serious medication errors or any other events requiring notification under existing legislative or Australian Council for Safety and Quality in Health Care guidelines

Likelihood – please tick the appropriate level of possible frequency

☐ **1. Rare** – Likely to recur only in exceptional circumstances

☐ **2. Unlikely** – Might possibly recur at some time every 2-5 years

☐ **3. Possible** – Could occur at some time every 1-2 years

☐ **4. Likely** – Will probably or may occur several times per year

☐ **5. Frequent** – Expected to occur either immediately or within a short time

D. Details of the event

Please use the table below as a prompt or guide to identify issues/factors you consider are present that may have contributed to the outcomes of the case. Where a box is ticked a specific issue should be raised in the comments section.

Factors influencing clinical practice

Organisational/Environment

☐ Staffing levels, workload and skill mix

☐ Resource or equipment constraints

☐ Access to other acute facilities or treatment options

☐ Access to community services, transport, etc.

Patient Factors

☐ Case complexity or complication

☐ Communication/language

☐ Social factors

Communication

☐ Content of medical record

☐ Legibility of medical record

☐ Supervision/support – access to

☐ Discharge arrangements and plan developed

☐ Communication between clinicians/handover

☐ Communication to/from other agencies

☐ Information provided to patient/carer

Medical Management

☐ Initial medical assessment and history

☐ Diagnostic tests – choice and timeliness

☐ Diagnosis – appropriate and timely

☐ Treatment plan – development and documentation

☐ Clinical guidelines – appropriate use

☐ Treatment, monitoring, transfer – appropriate and timely

☐ Medication orders – appropriate and timely

☐ Previous treatment at other agencies

Task Factors

☐ Education, training and credentialling

☐ Protocols or guidelines – availability and/or use

☐ Results – availability and communication

☐ Treatment plan – implementation

Please summarise the relevant CLINICAL DETAILS related to this case

Please summarise SPECIFIC issues arising from your review of this case

E. TIME TAKEN TO REVIEW MEDICAL RECORD

Minutes: **Reviewer's Signature:** **Date:**

Example Adverse occurrence screening /Targeted case note review report

< Health Service >
< Unit/Department/Service >

Patient UR	Admission date	Discharge date
Examples of screening criteria (circle all met during admission) *NB screening criteria should be adapted to meet local clinical requirements*	1. Death 2. Transfer to ICU from wards 3. MET call 4. Unplanned readmission within 28 days 5. Other	
An *adverse outcome* is an untoward patient event, which under optimal conditions is not a consequence of the patient's disease or treatment.		
Please review the care given and rate whether an adverse outcome was caused by medical management. **Circle the appropriate number.**	1. Little or no evidence of an adverse outcome caused by management 2. Slight evidence 3. Not quite likely (< 50/50 odds but a close call) 4. More likely than not (> 50/50 odds but a close call) 5. Strong evidence 6. Virtually certain evidence	
If an adverse outcome did occur (i.e. rated 4 or above) – where did it occur?		
Within this hospital	Another hospital	Outside hospital
If an adverse outcome did occur (i.e. rated 4 or above) – please provide brief clinical details.		

Please code the severity of the adverse outcome (please circle)		
0	**Minor severity**	No disability No significant patient discomfort No functional impairment No increased LOS
1	**Minor temporary**	Minimal to moderate clinical effect Requiring minimal or no clinical intervention No increased LOS No re-presentation for same or related problem
2	**Minor permanent**	Minimal to moderate clinical effect Permanent residual without cosmetic impairment No functional impairment
4	**Major permanent**	Moderate to severe clinical effect No significant functional effect No significant cosmetic effect Increased LOS or re-hospitalisation Requires moderate to major clinical intervention
5	**Potential major or major continuing**	Doubt about outcome but probability is of major impairment or re-presentation to hospital. Outcome may result in major impairment
6	**Death**	

Preventability (please circle)	
1	Little or no evidence for preventability
2	Slight or modest evidence for preventability
3	Preventability not quite likely (< 50/50 odds but close call)
4	Preventability likely (>50/50 odds but a close call)
5	Strong evidence for preventability
6	Virtually certain evidence for preventability
What further action would you recommend? (please circle)	
1	None
2	Presentation of case at MMR meeting
3	Discussion with the doctor involved by medical lead
4	Requires: • major intervention, and • formal Root Cause Analysis, and • informing hospital insurers of this case
5	Other – please specify

Further comments

Reviewer's name and signature **Date of review**

Completed forms should be forwarded to the medical lead with responsibility for the Adverse occurrence screening/ Targeted case note review for collating and action (if required).

Mortality and morbidity reviews/ Case discussion meetings

Definition

A routine, structured forum for the open examination and review of cases which have led to illness or death of a patient, in order to collectively learn from these events and to improve patient management and quality of care.

Background

Morbidity and mortality reviews (MMRs) originated in America. Ernest Amory Codman, a prominent 20th century New England surgeon suggested that each patient should have an 'end result card' where details of care and outcomes were recorded and publicly available. The first recognisable MMR was held in 1935 and related to anaesthesia outcomes.

MMRs are a regular, organisationally convened meeting, predominantly involving medical practitioners (but increasingly multi-disciplinary) who gather to discuss selected cases for the purposes of clarifying medical management and to provide a forum for teaching and system level learning – focusing on patient safety and quality improvement, including the identification and reporting of errors.

Cases may be chosen because they meet specific criteria (for example, identified through an Adverse Occurrence Screening/Targeted case note review (AOS/TCNR) program) or because they are of interest as a learning exercise.

The frequency, length, method of selection and analysis of cases all vary considerably, therefore it is difficult to formulate an evidence base for MMRs as few are conducted in the same way.

The studies that have been conducted (as opposed to reports of outcomes of MMRs for individual services) indicate that they can be an effective tool for education and quality improvement, if a safe environment is established. Evidence of their ability to assist in the identification of errors is mixed.[4]

An effective MMR should:

- identify key events resulting in adverse patient outcomes
- foster open and honest discussion of those events
- identify and disseminate information and insights about patient care that are drawn from individual and collective experience
- reinforce system level and individual accountability for providing high quality care
- create a forum which supports open and honest discussion through the provision of a just, patient centred culture
- contribute to clinical governance processes.

[4] The literature review for *MMR* is available at www.health.vic.gov.au/clinicalengagement

Purpose

MMRs are primarily a tool for examining opportunities for system level improvement. The purpose of MMRs is not to assess an individual senior doctor's care per se, but to provide a forum or learning opportunity to assist system level improvement, based around the identification and discussion of key issues.

MMRs may provide information to support a greater understanding of clinical practice at the individual senior doctor or clinical team level, but only when conducted in a consistent, reproducible fashion within a 'just' culture which emphasises and supports clinical excellence through open discussion of key patient care issues.

Design principles for successful use of the tool

MMRs are most valuable as a driver of culture change and clinical improvement when there is:

- a focus on patient care
- support and leadership by senior medical staff – this ensures appropriate peer input and engagement
- a multidisciplinary approach with input from all staff involved
- a consistent and reproducible approach
- organisational support
- a clear link to organisational clinical governance processes.

In addition to these listed above, other key strategies which can contribute to the efficacy of MMRs as a quality improvement and learning process include:

- a safe and supportive environment
- a structured process, including a framework to investigate underlying contributing factors
- a detailed feedback and follow up program.

An example of a structured process is the Learning from a defect tool developed to enhance MMRs (Pronovost, Holzmueller & Martinez 2006). The tool is described as a shorter version of root cause analysis (RCA) and is intended to improve safety and teamwork culture, by providing senior doctors with a structured framework to:

- identify what happened with regards to the adverse event
- determine why the adverse event happened
- implement interventions to reduce the probability of its re-occurrence
- enable those involved to evaluate the effectiveness of those interventions.

To improve MMRs consider:

- a review of the literature relating to the particular case
- the use of summaries to allow doctors, particularly junior doctors, to write up the findings for publication.

How to undertake MMR meetings

MMRs should be undertaken at a level which ensures that peer input is appropriate and available. For smaller hospitals this may be at a whole of hospital or even an interhospital level. For larger hospitals, this may be at the level of a clinical service, department or unit. In general, the approach to developing MMR should mirror the organisational approach to AOS/TCNR, as the AOS/TCNR program should identify most of the cases to be discussed in a MMR setting.

1. MMRs should occur onsite.
2. MMRs should be chaired by a senior doctor who takes responsibility for the process and in doing so has an ability to engage with clinical colleagues and to facilitate change at the patient care level. This may be the medical director, unit/department head or delegate.
3. Where possible, MMRs should be regularly scheduled to maximise participation.
4. Members of other clinical disciplines and junior medical staff should attend.
5. Cases for discussion should be identified by:
    - AOS/TCNR programs
    - senior doctors raising specific cases
    - referral from other MMR meetings.
6. In order to provide sufficient time for adequate discussion no more than two cases should be discussed per hour, although aggregating cases with similar issues into a 'block' discussion may be appropriate.
7. Senior doctors and other clinicians actively involved in the care of the patient to be discussed must be made aware of the intention to discuss the case at least 72 hours prior to the case and must be made aware of the date, time and place of the meeting. If they are unable or unwilling to attend the meeting where the case is to be discussed, the case should be referred to the appropriate medical lead for further investigation or action. Cases must never be discussed in the absence of the senior doctors with primary responsibility for care of the patient.
8. Cases should be presented in verbal format in a de-identified fashion, describing only the facts of the case including any confounding factors.
9. The major issues should be identified during the presentation, with the chair providing further clarification if required.

10. The chair should ensure that following the presentation, the key discussion points are agreed. These should always include:
    - What went wrong (or right)?
    - How did it go wrong (or right)?
    - Why did it go wrong (or right)?
    - What could we do differently in future?
    - What are the key lessons for the organisation?
11. A consistent approach to problem solving should be used to discuss the case.
12. The chair should ensure that any discussion relates to the facts of the case and not to personal issues. This is not a meeting to attack or openly criticise individuals who have contributed to patient care – doing so impedes the development of a 'just' culture.
13. If major performance issues relating to an individual senior doctor become apparent at any stage during the discussion, the chair should immediately halt the discussion and refer the issue to the relevant medical lead (medical director, unit head or equivalent), who should then initiate the organisation's usual performance development processes. Discussion around other matters pertaining to the case may continue.
14. At the completion of the discussion, action points should be agreed and prioritised by all present in the meeting. Responses to these issues should be presented at subsequent meetings.
15. Minutes should be kept – patient and doctor details should be de-identified.
16. An action list and appropriate accountabilities should be generated and circulated to all participants and to appropriate organisation level clinical governance structures.

Critical risks to consider in using the tool

MMR meetings should be conducted with a view to enquiry for the purposes of improvement. They must not be perceived as being punitive. It must be safe for all participants.

The major barrier to effective MMRs is the focus on individual senior doctor rather than a more general, systems approach to issues. This results in a fear of incrimination and recrimination.

Significant problems with an individual's clinical care which are readily apparent to medical leaders should not be dealt with in an MMR process. Clinical performance issues related to an individual senior doctor would normally be detected through other mechanisms (for example, AOS/TCNR, repeated patient complaints). These issues should be managed using the *Partnering for performance* framework in line with the organisation's performance development and support policy. MMR is not the appropriate forum for this and indeed may be counterproductive.

Limitations for MMRs include:

- administrative issues – lack of data
- procedural concerns – includes hindsight and reporting bias, a focus on diagnostic errors, and infrequent occurrence of MMRs
- educational issues – lack of educational/system learning focus.

Victorian approach

All senior doctors working within Victorian public hospitals should participate in some form of regular (for example, as a minimum quarterly) MMR meeting as part of their commitment to their clinical governance responsibilities.

1. This should occur at a level which allows appropriate peer input into the process:
    - for small hospitals, this will generally be at the whole of hospital level
    - for larger hospitals this may be at the level of a unit or department (there would need to be sufficient senior doctors with the same skill set in the unit/department to ensure a degree of independence from the care of the patient)
    - MMR processes should be standardised – the approach outlined above is a suggested minimum, but organisations may extend this process as required.
2. MMR should consider cases primarily identified through the AOS/TCNR process, in addition to other cases of interest identified through other organisational processes.

An example MMR reporting pro forma is available at www.health.vic.gov.au/clinicalengagement

Example MMR meeting report

< Health Service >

< Unit / Department / Service > MMR meeting report

Date and time of meeting			Chaired by		
Present at the meeting					
Case(s) or issue(s) discussed (de-identified – brief description of case details only)	**Key senior doctors responsible for the care of the patient during this episode present for case discussion?**	**Major patient care issues identified by discussion**	**Proposed actions**	**Group or person responsible for actions**	**Follow up by unit/ service/department When? How?**
1.					
2.					
This serves as a record of this MMR			Signed by Chair		Date

- Copy of report to go into unit MMR files and to appropriate organisational clinical governance processes.
- Consider sending copy of report to all members of unit/department/service as record of minutes of the meeting.

Clinical audit

Definition

The systematic review of elements of clinical care against predetermined criteria, with the aim of identifying areas for improvement and then developing, implementing and evaluating strategies intended to achieve that improvement.

Background

Clinical audit is a cyclical process where individuals, teams or services:

- identify a clinical topic of interest or concern
- identify sources of appropriate data which will assist in assessing the topic, including medical records and feedback from senior doctors, other clinicians and consumers
- review the data against set criteria and standards
- identify areas for improvement
- implement those improvements
- assess the impact of those improvements.

Audits measure elements of care including structure, processes and potentially outcomes of care. Clinical audit can provide information about the quality of care provided in a narrowly defined clinical area (for example, a single disease state or a single presentation).

Clinical audit generally uses clinical level data and when managed by senior doctors has high levels of acceptability and is viewed as a valuable means of informing doctors about their care delivery. By contrast, traditional clinical indicators have less acceptability amongst doctors as their data sources may be non clinical data sets and because the measures chosen may not have local clinical applicability.

Professional bodies such as the medical colleges support and encourage their members and fellows to participate in clinical audit. Participation in clinical audit is mandatory as part of a continuing professional development (CPD) program for some specialist colleges.

Successful clinical audit requires:

- a clearly defined issue or problem
- an ability to measure clinically relevant elements of care which clearly reflect that problem
- an ability to apply that measure in a rigorous and consistent way which best reflects patient care
- an ability to change care processes to drive any subsequent improvement in the chosen measure
- sufficient resources to ensure that the work can be undertaken appropriately and in a manner which ensures clinician engagement and support
- clinical leadership.

The quality of the information obtained by clinical audit is a direct reflection of the design and conduct of the audit.

Clinical audit should always be subject to informal peer review to ensure local relevance and to maximise acceptance.

Two Cochrane systematic reviews and a meta-analysis have been conducted on the use of audit and feedback on professional practice and health care outcomes (Jamtvedt et al 2003; Jamtvedt et al 2006). The reviews show that audit has a moderate impact on clinical practice, but the impact of audit is dependent on the level of performance prior to the audit, and on the feedback process. The establishment of valid criteria, the training of reviewers, particularly if they are conducting their own audits, and the provision of effective feedback are important factors in the validity of the method.[5]

Comparisons between clinical settings are difficult as participants and the interventions themselves vary. Thus clinical audit should be seen as an organisation or service specific activity. In the absence of consistent processes for data management and reporting, considerable caution should be applied in interpreting inter hospital or inter unit comparisons.

Purpose

The purpose of clinical audit is to improve the quality of health care services by systematically reviewing the care provided against set criteria. To do so, there should be a clear understanding of current practice. This requires:

- clear and consistent definitions
- consistent and reproducible data sources
- an ability to change care delivery if improvement is required.

The gap between the criteria and the assessed performance provides guidance for prioritising improvement strategies.

Clinical audits that are ongoing and allow the monitoring of care over time may become 'clinical indicators' (see *Clinical indicator* tool). Clinical indicators based on ongoing clinical audit using clinical level data are likely to have significant clinical acceptability.

Clinical audit may, in certain circumstances, provide guidance around elements of an individual senior doctor's clinical performance (for example, colonoscopy perforation rates).

Clinical audit, if well designed, appropriately managed, resourced and supported by those senior doctors whose care is being audited, provides reasonable clinical level evidence of elements of a senior doctor's care delivery. Clinical audit will rarely provide evidence of 'whole of care'. For this reason, care should be taken in interpreting clinical audit information in the performance context. Clinical audit may provide an excellent opportunity to facilitate dialogue with senior doctors and enhance clinical practice.

[5] The literature review for Clinical audit is available at www.health.vic.gov.au/clinicalengagement

How to undertake clinical audit

The department is not prescribing a specific approach to clinical audit as there is considerable literature on the successful undertaking of clinical audit. Individual professional colleges often provide craft group specific guidance.

The department notes, however, the importance of ensuring sufficient resources to successfully complete the audit cycle and strongly encourages hospitals to work with their senior medical staff to design the most appropriate structure and supporting processes in the local context.

A useful resource to support the local development of clinical audit is the NHS National Institute for Clinical Excellence *Principles for best practice in clinical audit* (2002).[6] Professional colleges also provide guidelines for undertaking clinical audit.

Critical risks to consider in using the tool

Clinical audit will fail if key barriers are not addressed prior to the commencement of the audit process.

Key barriers include:

- lack of clarity re purpose of audit (what are we trying to achieve?) – audit must be framed around improving patient care and has no role as an investigational tool
- inconsistent approaches to data collection and management
- insufficient resources to support the audit process
- lack of expertise in audit project design and analysis
- lack of planning
- lack of medical engagement and leadership
- poor professional culture and poor relationships between professional groups and agencies, and within audit teams
- absence of trust between senior doctors and managers
- lack of integration with other activities (including clinical governance processes)
- an inability of senior doctors to change or improve the care processes being measured.

Clinical audit can provide a valuable source of data for reviewing elements of clinical performance. However, this data should not be used as the sole source of information to inform a performance development process for a senior doctor.

Victorian approach

Every senior doctor in Victorian public hospitals should be supported by their organisation to ensure they are involved in auditing elements of their clinical care on at least an annual basis. Ideally clinical audit should be ongoing to assist in the monitoring of care. Senior doctors should be involved in the management of clinical audit, including the design, oversight and subsequent improvement processes.

[6] More information is available at http://www.nice.org.uk/media/796/23/BestPracticeClinicalAudit.pdf

Clinical indicators

Definition

Clinical indicators are measures of elements of clinical care which may, when assessed over time, provide a method of assessing the quality and safety of care at a system level.

Background

Clinical and performance indicators have been in use by health services since the 1980s. An increased awareness of quality and safety issues, coupled with accreditation and regulatory requirements in recent years has seen the expansion and development of clinical indicators for specific disease and service types, as well as to overarching areas such as clinical governance and patient safety.

Clinical indicators are measures of the process, structure and/or outcomes of patient care. They are used by health systems and services, as well as accreditation and regulatory bodies, to identify areas of concern which might require further review or development. Clinical indicators identify rates of occurrences which are either under or over expected levels. They may also allow clinical care to be followed over a period of time, or to be benchmarked against other health care agencies.

Types of indicators include: rate based indicators, structural indicators, process indicators, outcome indicators, generic indicators, disease specific indicators, type of care indicators, indicators of function, modality indicators, professional indicators, patient safety indicators, clinical governance indicators, culturally specific/culturally sensitive indicators.

Clinical indicators are generally collected by organisations from a range of data sets including administrative data sets. Local or state based clinical audit programs (for example, *Vascular surgery audit program*[7]) may over time provide a reliable range of indicators.[8]

[7] More information is available at http://www.health.vic.gov.au/surgicalperformance/vascular.htm

[8] The literature review for *Clinical indicators* is available at www.health.vic.gov.au/clinicalengagement

Purpose

Clinical indicators have multiple purposes depending on the user (managers, senior doctors, regulators, patients) including to:

- document the quality of care
- benchmark care (to make comparisons over time and between services)
- make judgments about services
- set service or system priorities
- organise care
- support accountability, regulation, and accreditation
- support quality improvement
- support patient choice of providers.

Clinical indicators may point to system level issues, however they are rarely specific enough to provide an insight into an individual doctor's clinical performance.

Indicators are assessed on the basis of the strength of scientific evidence for their ability to predict outcomes. An 'ideal' indicator should be: (Mainz 2003)

- based on agreed definitions, and described exhaustively and exclusively
- highly or optimally specific and sensitive, i.e. it detects few false positives and false negatives
- valid and reliable
- able to discriminate well
- able to relate to clearly identifiable events for the user (for example, it is relevant to clinical practice)
- permit useful comparisons
- evidence based.

As well as meeting these criteria, clinical indicators should: (Wollersheim et al 2007)

- give an indication of the quality of the patient care delivered
- comply with high quality standards
- be constructed in a careful and transparent manner
- be relevant to the important aspects of quality of care
- measure the quality in a valid and reliable manner with minimal inter and intra-observer variability so that they are suitable for comparisons between professionals, practices, and institutions
- be selected from research data with consideration for optimal patient care (preferably an evidence based guideline), supplemented by expert opinion
- be relevant to important aspects (effectiveness, safety and efficiency) and dimensions (professional, organisational and patient oriented) of quality of care
- be feasible (that is, be appropriate, measurable and improvable) as well as valid and reliable
- be defined exactly and expressed as a quotient.

Any clinical indicator program must have been considered and developed with the involvement of the senior doctors concerned with delivery of the care measured by the indicator. Clinical indicator measures should also be made available on an ongoing basis to all senior doctors providing the care.

The Australian Patient safety indicators (AusPSIs) (developed in Victoria) are a set of indicators which monitor clinical outcomes.[9] These recently developed indicators are now being reported to hospitals. PSIs are measures of health care safety that make use of readily available hospital inpatient administrative data. There are varied views on use of administrative data for the purpose of understanding clinical practice. It should be acknowledged that PSIs are indicators – not definitive measures of the frequency of adverse events. Further investigation at the local or organisational level may occasionally be necessary to gain a greater understanding of these measures.

Where clinical indicators arise from clinically derived data sets (for example, clinical registry data) their acceptance by senior doctors is likely to be high.

Critical risks to consider in using the tool

Once the clinical indicator is implemented the results should be presented in such a way as to account for their causal and contributing factors including descriptions of the clinical context, socio-demographic variables of patients, and case mix.

Clinical indicators must:

- inform an improvement strategy, and therefore must be sensitive to improvements over time
- be technically robust and interpretable at the level of clinical care delivery
- be embedded in organisational governance systems with an emphasis on using this information to improve patient care.

Failure to do so limits the utility and acceptance of the indicator as a quality measure.

[9] More information is available at: http://www.health.vic.gov.au/psi/auspsi

Victorian approach

Clinical indicators may provide a means of understanding broad elements of patient care. Considerable caution should be demonstrated in attempting to link clinical indicators to an individual's clinical performance.

Careful judgment should be exercised by medical leaders where evidence and particularly repeated evidence of suboptimal performance is suggested by clinical indicators. This will rarely be attributable to individual senior doctors. Where there is a suggestion that this is the case, other corroborative evidence should be sought and carefully considered as part of an overall process of understanding an individual's performance. This process should always be medically led. Clinical indicators suggesting underperformance should be addressed using the *Partnering for performance* framework in line with the organisation's performance development and support policies, but should not be used as part of an individual's performance review process unless attribution can be clearly proven.

Clinical indicators should therefore only be used in the most general terms as part of an individual's ongoing cycle of performance development processes or a formal peer review process.

Clinical indicators should always be presented as part of an improvement strategy. Senior doctors must be actively engaged by the organisation to take ownership of the improvement process.

Where possible, senior doctors should be supported by their organisation to contribute clinical data to relevant clinical registries.

Patient satisfaction and complaints

Definition

Satisfaction – the degree to which the patient's expectations, goals and preferences are met by the health service.

Patient complaints – arise from dissatisfaction with elements of their health care experience.

Background

Patient complaints have long been used in the health system to measure dissatisfaction, but it is only in recent decades that formal patient satisfaction surveys have been used to endeavour to understand aspects of the quality of care. A link between this measure and patient safety has been made.

The measure of patient satisfaction and complaints is an attempt to capture elements of the quality of care as perceived by patients. These elements include: the art of care (caring attitude); functional quality of care; accessibility and convenience; finances (ability to pay for services); physical environment; availability; continuity of care; efficacy and outcome of care.

The evidence for the role of patient satisfaction data in quality improvement is mixed.[10] While some research reports no effect of feedback based on patient evaluations on behaviour change, other studies report the opposite. There is evidence that patient satisfaction survey data is under utilised by staff, which may help explain the reported lack of change. Measures relying on complaints have been shown to be more responsive to change than those relying on satisfaction measures.

High levels of patient satisfaction are however known to be associated with a more positive ongoing relationship with health care providers and with improved adherence to recommended care.

A major theme in the reviewed literature is the complexity of capturing a measurement of patient satisfaction that will accurately inform quality care improvement measures. That is, individual patient satisfaction may be influenced by many variables including: age, reported health status, ethnicity, gender, engagement with the system, faith and gratitude, perceptions of what constitutes 'good' physicians or care and time elapsed since receiving care.

Methodological issues associated with the evaluation and processing of complaints, the interpretation of complaint data and the process by which complaint data can best influence decisions about quality improvement have been examined.

[10] The literature review for *Patient satisfaction and complaints* is available at www.health.vic.gov.au/clinicalengagement

Adjustment for the variables that predict patient satisfaction scores is vital in gaining an accurate measure of patient satisfaction. It is also important to account for the effect of non participation by those with negative views and patient groups such as the elderly, confused and very ill from whom satisfaction data is difficult to obtain in collective patient satisfaction measures.

Patient complaint data have been used in the quality improvement process and have resulted in changes to policy and procedure. However, patient complaints may have detrimental effects on doctors and the relationship with their patients, as well as on fragile local health systems.

Complaints by health care providers (about other health care providers) are also an important source of information.

Measurement of patient satisfaction is now widely practiced across many health care settings. Patient satisfaction or dissatisfaction (and the complaints which subsequently arise from dissatisfaction) is thus an outcome of many different elements, many of which will be beyond the direct control of an individual doctor.

The Victorian patient satisfaction monitor (VPSM) monitors the level of adult in-patient satisfaction with the care and services provided by the State's public acute and sub acute hospitals.[11] It 'aims to elicit patients' perceptions about their health care experience so as to provide hospitals with vital information that will inform health service quality improvement' (Ultrafeedback 2008, p. 11). The survey is not intended to, and does not, provide feedback at ward, departmental or individual clinician level.

Purpose

Understanding patient satisfaction can contribute to a better understanding of the overall pattern of care delivery. Because of the broad based, multidimensional nature of patient satisfaction, it is rarely possible to draw significant conclusions about an individual senior doctor's performance, although multiple complaints about a specific individual should trigger further review. Patient satisfaction surveys and patient complaint data can be readily integrated elements of clinical practice improvement programs.

[11] Further information is available at http://www.health.vic.gov.au/patsat/index.htm

How to use patient satisfaction and complaints

The VPSM and individual organisation level patient satisfaction activities should be interpreted with considerable caution if considering them in the context of understanding the performance of an individual senior doctor. They should only be used in the most general terms as part of an ongoing cycle of performance review or a formal peer review process.

Patient complaints sometimes suggest direct attribution to individual doctors or teams. Patient complaints should be addressed according to usual organisational governance processes, but should not be used as part of an individual's performance development and support process unless attribution can be clearly proven.

Senior doctors should always be made aware of any complaint in which they are mentioned by name or implication. Cases of dissatisfaction in which attribution is apparent (for example, "I was unhappy with Dr X's approach to my care") should always be discussed with the senior doctor concerned by the individual's medical lead (medical director, unit head or equivalent) in an open and non judgmental fashion. A jointly agreed record of that conversation should be kept by the medical lead in accordance with the organisation's *Partnering for performance* policy. This record can then be used to inform ongoing performance development and support processes with the doctor and may, where appropriate, contribute to peer review processes such as re-credentialling.

Critical risks to consider in using the tool

The principal risk in use of patient satisfaction and complaints as a measure of 'quality' or 'performance' is the issue of attribution. Misuse of this tool carries significant risk to the organisation's relationship with senior doctors.

Victorian approach

Doctors should be made aware of any complaint about them. The doctor's medical lead (medical director, unit head or equivalent) should initiate further investigation of any cases of multiple complaints. Great care should be taken in using complaints or evidence of patient dissatisfaction in monitoring the performance of individual doctors.

Case studies – Using *Partnering for performance*

Contents

These case studies are designed to provide examples of how health services can use *Partnering for performance* and how they might manage certain performance situations. They are not intended to provide formal guidance to organisations or doctors, but merely to illustrate the core principles of *Partnering for performance*. Health services should ensure that they have appropriate policies and procedures in place to manage similar situations.

Case study 1

Underperformance managed at the local level

A surgeon (Dr X) is appointed to a country hospital with a scope of practice in general surgery. He reports to the head of surgery.

Initially his work appears to be of acceptable standard, with length of stay data similar to his peers and with no complaints or concerns expressed by staff or patients. After a few months, patient complaints begin to reach the head of surgery specifically mentioning Dr X and highlighting problems with communication.

In addition, senior theatre staff raise concerns with theatre management and the head of surgery about Dr X's operative performance and teamwork. Junior medical staff also quietly express their concerns to the head of surgery about Dr X. Hospital patient deaths have been reviewed as part of the organisation's targeted case note review program, with no specific issues being found.

As part of an informal performance conversation, the head of surgery feeds back the information about patient and staff concerns to Dr X. Dr X reports recent issues with depression related to a relationship breakdown, in part related to the family's move to the country.

With the support of the organisation, Dr X seeks the assistance of a local general practitioner and takes some time off work. Upon return to work a few weeks later, Dr X's performance is monitored by the head of surgery, with ongoing informal feedback from Dr X and his surgical colleagues. No further complaints are received.

A subsequent formal performance review using the *Partnership for performance* framework confirms ongoing acceptable performance. Dr X's performance continues to be monitored and supported by the head of surgery and his peers throughout the credentialling cycle.

Case study 2

Clinical department based monitoring identifies underperformance by an individual

A physician (Dr Y) working in a gastroenterology department of a major teaching hospital has a reputation for being 'difficult' and not being willing to open his clinical care up to the scrutiny of colleagues. Whilst patient complaints are rare, colleagues have expressed informal concern amongst themselves and to their head of department.

The gastroenterology department has recently revised its performance monitoring process in line with the introduction of the hospital's new performance development and support process.

The department's members (including Dr Y) have collectively committed to monitoring and supporting the performance of all gastroenterologists using a range of clinical measures. In addition, the department has collectively agreed to a process of informal peer review of all clinical activities through unit based mortality and morbidity meetings and targeted case note review. An in house patient satisfaction survey has been developed to be given to all patients of the service.

As these activities are undertaken over the following months, it becomes apparent that Dr Y's clinical measures lag behind those of his colleagues, and that his patient satisfaction is low, mainly due to communication issues. In addition, it is apparent through an informal colleague based feedback process that Dr Y is underperforming in terms of his supervision, teaching and research responsibilities.

The head of department raises these concerns with Dr Y in an informal conversation and subsequently presents this information to Dr Y at a scheduled formal performance development meeting. In discussion, it becomes apparent that Dr Y wishes to reduce his clinical role within the department, predominantly due to rising pressures from his private practice. Dr Y and his head of department negotiate changes to his role within the department. Dr Y also commits to the ongoing monitoring and peer oversight of his clinical practice, and improving his communication and relationships with other team members. Dr Y agrees that the process has had considerable value, as he had previously been unaware of concerns about his behavioural issues. Subsequent performance reviews confirm that Dr Y's clinical care has improved, and that relationships within the team have also improved.

Case study 3

Underperformance not able to be managed at the local level is escalated to an organisational response

A gynaecologist (Dr G) has been working in a medium sized hospital for some years. Recently, she has undertaken a number of operations which may be regarded as being at the edge of her scope of practice.

Concerns have been raised with management by other medical staff including anaesthetists. The performance of all senior doctors has been monitored through a targeted case note review program and through the hospital's standardised mortality and morbidity process. Concerns have arisen through these processes about the nature of some of Dr G's surgical procedures and her defined scope of practice. Concerns have also been expressed to medical leadership by nursing staff and a number of patient complaints have been received through the organisation's complaints process.

Informal discussions between Dr G and her head of department have suggested that Dr G is not concerned about these issues, believing that she is working within her scope of practice, but she is willing to have her practice reviewed.

The head of department arranges to meet with Dr G to discuss the concerns and to review elements of her clinical practice. In discussion with Dr G, it is agreed that this review will focus on the five most common surgical cases she has undertaken in the last five years and cases where specific concerns have been raised. She agrees that her clinical practices will be compared with her colleagues.

Clinical data appears to suggest (when compared with her colleagues) an excessive length of stay for this patient group, a higher rate of post operative infection, and greater use of the intensive care unit in the post operative period.

Dr G challenges the findings of the review process, and refuses to consider modifying her practices. Due to the ongoing concerns about Dr G's practices and the potential risk to patients and the organisation, the head of department escalates his concerns to an organisational response.

A formal peer review process is instituted with Dr G's consent, using a number of expert external peers with experience in similar clinical settings. The process occurs within the context of the organisation's credentialling and scope of practice processes, in line with Victoria's *Credentialling and defining the scope of clinical practice for medical practitioners in Victorian health services* policy (Department of Human Services 2007). A range of jointly agreed clinical and non clinical measures are reviewed, together with a number of specific cases where concerns have been raised through the mortality and morbidity review and other processes.

The fact that the organisation is undertaking a peer review process is not communicated to the medical board, as at this stage it is not clear that patient safety is at risk. The organisation notifies its insurer prior to the commencement of the peer review process. The insurer notes that the process meets its current insurance guidelines.

The formal peer review process finds that Dr G's performance in a range of clinical settings is acceptable, but that her performance in a number of specific operations is suboptimal with clinical results being less than might be expected. The review recommends that Dr G undertake additional training in those operations before recommencing them. It also recommends that her performance in those operations be subject to ongoing monitoring using routine clinical measures augmented by a cumulative sum (CUSUM) technique and supported by an external peer reviewer.

Dr G accepts the findings of the review and undertakes the necessary upskilling to improve her performance. Over the ensuing three years to her next scheduled re-credentialling, she maintains her performance at an acceptable level.

Case study 4

Using a structured approach to mortality and morbidity review (MMR) meetings reduces departmental tension and improves patient care

A surgical department has a long history of difficulties dealing with case review, partly due to issues with communication based around a combative culture. In the past, colleagues have openly criticised each other in front of junior medical staff and other clinical staff, leading to significant dissatisfaction and formal complaints to senior colleagues from junior medical staff about a lack of personal safety in the meetings.

In addition, it was widely felt by many department members that patient safety and quality issues identified during the MMR process were not acted upon. This has resulted in important cases not being presented to the regular MMR meeting and in key surgeons not participating. There is considerable dissatisfaction with the current situation. All of the surgeons recognise the importance of peer support for clinical practice and agree that MMR processes are important elements of quality care.

In response to these concerns the department head, with the agreement of his department, institutes a new approach to MMR meetings, based on the Victorian *Understanding clinical practice toolkit*. A transparent approach to case selection was developed, together with an agreed approach to managing the meetings, including strict rules about how people are to treat each other during the MMR meeting. In addition, a clear reporting mechanism linking with the organisation's broader clinical governance processes was developed.

Over time, surgeons progressively re-engage with the process and real improvements in team culture and patient care are made as a clear plan for management of issues is enacted. All agree a more structured approach to MMR has been beneficial. The meetings are now seen as an important and safe learning opportunity for all participants.

Case study 5

Coordinating performance development processes across organisations with a shared credentialling committee

A surgeon provides visiting services on a contractor basis to a number of small hospitals (hospitals A, B and C) in rural Victoria. Due to their size and proximity, these hospitals have a joint credentialling committee (established as outlined in the *Credentialling and defining the scope of clinical practice for medical practitioners in Victorian health services* policy (Department of Human Services 2007)). The hospitals have each enacted a formal policy which requires their senior medical staff to participate in a performance development process, in accordance with existing contracts of appointment and *Partnering for performance*.

A significant clinical incident involving one of the surgeon's patients arises in hospital A. The medical director of hospital A expresses concern to the surgeon, and requests information about the surgeon's practices in hospital B and C, in order to gain a broader picture of the surgeon's practice. The surgeon agrees to this approach. A subsequent review of all similar cases conducted across the three hospitals suggests that this is an isolated clinical situation. The medical directors of hospitals B and C are not aware of any other concerns about the surgeon's practice in their hospitals.

As part of the surgeon's ongoing participation in a performance development process at hospital A, it is agreed that he will collect data from his surgical cases at all three hospitals (with the assistance of the other hospitals). This aggregated data will also be made available for his participation in performance development processes at hospitals B and C.

Case study 6

Managing apparent underperformance of an uncooperative doctor

A physician (Dr Z) provides contract based visiting services to a small regional hospital. The part time medical director has become aware of frequent complaints from staff and patients specifically mentioning Dr Z and a number of clinical incidents affecting Dr Z's patients have been detected through the organisation's adverse occurrence screening/ targeted case note review program. These issues have been discussed with Dr Z in the past as they have arisen.

Individually, these incidents appear minor without a clear impact on patient safety, but being concerned about a possible pattern of underperformance, the medical director arranges to formally meet with Dr Z. Previous informal performance conversations have been uneventful. This meeting is planned as a formal performance meeting under the *Partnering for performance* framework. The medical director is aware that Dr Z provides similar contractor based services to a number of small regional hospitals (although these hospitals are not linked and have separate credentialling and scope of practice committees). Dr Z does not have an appointment at a teaching hospital. Dr Z reluctantly agrees to the meeting but refuses to concede that there may be issues with his performance.

The medical director raises the specific clinical issues with Dr Z and asks Dr Z whether similar concerns have been raised at other hospitals where he provides services. The medical director has been aware of concern from his medical director colleagues about Dr Z's performance but due to privacy reasons is unable to raise this with Dr Z, or to use the information in a performance development context. Dr Z is unwilling to discuss his performance and refuses permission for the medical director to seek performance based information from the other hospitals at which Dr Z holds appointments.

The medical director, with the support of his CEO, contacts the medical board, citing concerns over performance and a breakdown in trust with Dr Z. The organisation's insurers are also notified and Dr Z is suspended from the hospital pending the medical board's review.

Case study 7

Using *Partnering for performance* to aid identification of training and career opportunities

A mid career anaesthetist (Dr A) at a large hospital is interested in clinical leadership and system improvement and is keen to move into a clinical management role. She has undertaken some postgraduate management study of her own volition and recognises an opportunity to apply some of those learnings locally. She is aware that the current head of department is moving towards retirement. Dr A has previously undertaken some department level responsibilities for quality activities and has had teaching and research roles.

As part of her ongoing performance conversations with the head of department she identifies her interest in further management opportunities, both within the department and the broader organisation. In discussions with the medical director, the head of department promotes Dr A's interest and recognises that she has considerable potential as a clinician manager.

The department head and Dr A identify a range of short and longer term clinical leadership opportunities, including the possibility of transition to department head. He arranges for Dr A to meet with the medical director (an experienced medical manager who has considerable external networks) to discuss possible training, professional development and personal mentoring opportunities. Dr A is encouraged to undertake formal masters level management training and is put in contact with a number of senior colleagues in other hospitals who are willing to provide her with support. Her head of department agrees to release Dr A from clinical duties for two sessions a week (under the hospital's 80:20 non-clinical time arrangement) in order to undertake further study. He also provides her with an expanded range of management responsibilities within the department, including creating a position of deputy, in the expectation that she will fill in during his regular leave.

Over time and with the ongoing support of both the department head and the organisation, it becomes apparent that Dr A is performing well in her management responsibilities and is contributing valuable knowledge from her studies and external networks, which the department and the broader organisation are able to use to benefit patient care. Her colleagues recognise as part of their ongoing informal peer review that not only is her clinical care exemplary but that Dr A is a very able replacement for the head of department. Upon his retirement, Dr A assumes the role of department head with the full support of her colleagues and the broader organisation.

Case study 8

Managing communication difficulties

Dr F has worked for a number of years in a regional hospital. He is generally regarded as being competent, with clinical performance being at an acceptable level. However, persistent concerns have been raised with the medical director over a period of time about communication with junior medical staff. Some junior staff have reported feeling that they have insufficient supervision by Dr F. Matters come to a head when a junior doctor on rotation from a major metropolitan hospital complains to the newly appointed medical director about Dr F's communication and attitude to junior doctor supervision.

The medical director has recently enacted an organisation wide approach to managing medical staff performance, in line with the Department of Health's P*artnering for performance* policy. All medical staff have been informed of this policy and have, through their medical staff group, agreed to its implementation.

The medical director arranges an informal conversation with Dr F and mentions the specific complaint of the junior doctor. Dr F agrees to work on his communication style and his relationship with junior staff. The medical director and Dr F agree that they will review these issues at Dr F's formal *Partnering for performance* conversation later in the year. Both agree to monitor the situation during this time. The conversation is documented by the medical director in an email to Dr F.

The medical director continues to seek specific feedback from junior medical staff over ensuing months and similar issues continue to be received. Whilst evidence from existing clinical measures suggests that patient care does not appear to have been affected, the medical director is concerned about the impact of this issue on junior medical staff and the organisation's reputation as a training site.

At the formal performance meeting the medical director raises the ongoing concerns and requests that Dr F undertake specific communication training as part of his goal setting for the following year. Dr F somewhat reluctantly agrees. Over the following months, the medical director and Dr F continue to monitor the situation during documented informal performance conversations. There are no further complaints by junior staff who report feeling considerably more supported. This information is fed back to Dr F at his next formal *Partnering for performance* meeting. Improved relationships are subsequently maintained.

Case study 9

Performance development and support processes for dentists

A dentist (Dr D) works at a public hospital and reports to the medical director. Dr D participates in the Dental Practice Board of Victoria's continuing professional development (CPD) scheme for registered dental care providers.

This hospital requires all its senior doctors (including dentists) to participate in a performance development and support process. This process uses the *Partnering for performance* framework and forms and includes regular informal conversations between a doctor and their medical lead and an annual formal performance conversation.

The medical director is a medical practitioner with no clinical experience in dental health. However the performance development process has been established so that clinical performance is monitored by peers.

During the credentialling cycle, Dr D has participated in a number of hospital based *clinical toolkit* activities including clinical audit and mortality and morbidity review meetings where dental cases have been discussed with peers (structured in accordance with the *Understanding clinical practice toolkit*).

Dr D has also participated in additional CPD activities through the Australian Dental Association (ADA) and Dental Health Services Victoria (DHSV) as this provides further opportunities for informal peer review with both private and public sector dentists.

As part of the performance development process Dr D provides evidence of his participation in the *clinical toolkit* activities. The medical director confirms that Dr D's peers agree that his clinical care is of an exemplary standard. The medical director also commends Dr D on receiving a number of patient compliments which directly mentioned Dr D. Together they discuss his goals for the coming year including opportunities for career progression.

Glossary, references and resources

Glossary

Adverse occurrence screening/Targeted case note review	The review of selected or targeted medical records by medical colleagues using screening criteria which may be associated with care related adverse events.
Appointment	The employment or engagement of a medical practitioner to provide services within an organisation according to the conditions defined by general law and supplemented by contract.
Australian patient safety indicators (AusPSIs)	Measures of health care safety that make use of readily available hospital inpatient administrative data. They screen for adverse events that patients experience as a result of their experience in using the health care system. These events may be amenable to prevention by changes at the system or provider level.
Clinical audit	The systematic review of elements of clinical care against predetermined criteria, with the aim of identifying areas for improvement and then developing, implementing and evaluating strategies intended to achieve that improvement.
Clinical engagement	The active contribution of doctors within their normal work to enhance the performance of the organisation which itself supports and encourages high quality care.
Clinical governance	The system by which the governing body, managers, clinicians and staff share responsibility and accountability for the quality of care, continuously improving, minimising risks, and fostering an environment of excellence in care.
Clinical indicators	Measures of elements of clinical care which may, when measured over time, provide a method of assessing the quality and safety of care at a system level.
Continuing professional development (CPD)	The process by which a professional person maintains the quality and relevance of their skills throughout their working life.
Credentialling	The formal process of verifying the qualifications, experience, professional standing and other relevant professional attributes of medical practitioners for the purpose of forming a view about their competence and suitability to provide safe, high quality health care services within specific organisational environments.
Credentialling cycle	The three to five year period following a senior doctor's appointment. At the completion of the cycle the doctor should undergo a formal re-credentialling process as outlined in the *Credentialling and defining scope of clinical practice for medical practitioners in Victorian health services* policy and enter a further credentialling cycle.
Credentialling and defining scope of clinical practice policy	The Department of Health's *Credentialling and defining scope of clinical practice for medical practitioners in Victorian health services* policy. It was released in 2007 and updated in 2009.

Governing body (Public health service boards)	Public health service boards are responsible to the Minister for Health for setting the strategic directions of public hospitals within the framework of government policy. They are accountable for ensuring that hospitals: • are effectively and efficiently managed • provide high quality care and service delivery • meet the needs of the community, and • meet financial and non financial performance targets.
Informal peer review	The process where peers provide ongoing, informal oversight of each other's clinical care delivery.
Just culture	A culture that is open, transparent and based in learning and system improvement yet has well established systems of accountability for an individual's actions.
Medical Board of Australia	The National board for medical practitioners established under the Health Practitioner Regulation National Law (operational from 1 July 2010).
Medical Practitioners Board of Victoria	A statutory authority established to ensure doctors maintain professional standards and practise medicine safely. The Board registers doctors, investigates complaints about doctors, monitors the health of doctors who are ill and may be unfit to practise medicine, and develops guidelines for the profession. Following the introduction of the National registration and accreditation scheme (1 July 2010) the state medical board will become a committee of the national board and will be delegated powers to continue to deal with registrations and notifications locally.
Medical director	The senior medical practitioner accountable within a health service for management of medical professional services. This will usually involve leading, directing, implementing, planning and evaluating the delivery of clinical services.
Medical lead	A medical leader with management responsibility for key elements of a clinical unit, service or department. May be the medical director, department or unit head or equivalent.
Mortality and morbidity reviews (MMRs)	A routine, structured forum for the open examination and review of cases which have led to illness or death of a patient, in order to collectively learn from these events and improve patient management and quality of care.
National registration and accreditation scheme	A single National registration and accreditation scheme for health practitioners (operational from 1 July 2010). The scheme includes ten health professions: chiropractors; dentists (including dental hygienists, dental prosthetists and dental therapists); medical practitioners; nurses and midwives; optometrists; osteopaths; pharmacists; physiotherapists; podiatrists; and psychologists.

Partnering for performance policy	The Department of Health's performance development and support process for senior medical staff.
Patient complaints	Patient dissatisfaction with elements of their health care experience.
Patient satisfaction	The degree to which the patient's expectations, goals and preferences are met by the health service.
Peers	A health practitioner with relevant clinical experience in similar health service organisational environments who also has the knowledge and skills to contribute to the review of another health practitioner's competence and performance.
Peer review	The process by which individuals of the same profession, experience and working in similar organisational settings, critically assess their colleague(s) performance, in order to reinforce areas of strength and quality in patient care, and to identify areas for development or improvement.
Root cause analysis (RCA)	A process analysis method, which can be used to identify the factors that contribute to adverse patient outcomes or near miss events. In Victoria a formal RCA must be conducted in response to a reported sentinel event.
Scope of practice	Follows on from credentialling and involves delineating the extent of an individual medical practitioner's clinical practice within a particular organisation, based on the individual's credentials, competence, performance and professional suitability and the needs and the capability of the organisation to support the medical practitioner's scope of clinical practice.
Senior doctor (Senior medical staff)	A medical practitioner with independent responsibility for patient care. Includes appointed dentists.
Sentinel event	Relatively infrequent, clear-cut events that occur independently of a patient's condition, commonly reflect hospital system and process deficiencies and result in unnecessary outcomes for patients.
Understanding clinical practice toolkit	A practical guide to a suite of common clinical tools for use by senior doctors and managers in Victorian public hospitals for the purpose of understanding an individual doctor's clinical practice.
Victorian health incident management system (VHIMS)	A system for collection and review of statewide incident information which includes an incident reporting data set and taxonomy for use by all Victorian publicly funded health services.

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