# Queensland Clinical Senate

*Connecting clinicians to improve care*

## Measuring performance to improve outcomes

## 30-31 October 2014
## Meeting Report

Royal on the Park, Brisbane, Queensland

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## Presenters and Panellists

- Mr Ron Calvert, Chief Executive, Gold Coast Hospital and Health Service
- Ms Veronica Casey, Executive Director of Nursing, Metro South Hospital and Health Service
- Dr Ian Coombes, Director of Pharmacy, Royal Brisbane and Women's Hospital
- Ms Brooke Cowie, Speech Pathologists, Metro North Hospital and Health Service
- Dr Michael Daly, Executive Director, Clinical Governance, Metro South Hospital and Health Service
- Ms Michelle Garner, Executive Director of Nursing, North West Hospital and Health Service
- Mr Scott Hartley, National Managing Partner & Public Sector Lead, Grant Thornton
- Mr Ian Maynard, Director-General, Queensland Health
- Dr Denise MacGregor, General Surgeon, Wide Bay Hospital and Health Service
- Mr Phil Pareezer, Senior Manager, Queensland Health and Aged Care Lead, Grant Thornton
- A/Professor Ian Scott, Director of Internal Medicine and Clinical Epidemiology, Princess Alexandra Hospital, Metro South Hospital and Health Service
- Mr Mark Tucker-Evans, Chair, Health Consumers Queensland

## Meeting Facilitator

Mr Stephen McKernan QSO

## Summary

As part of the extensive health reform program currently underway in Queensland, attention has been directed to measurement of clinician performance to assist in the evaluation of the effectiveness of health services. Specifically, individual performance indicators have been recently introduced for senior doctors in Queensland. It is likely a similar expectation will be introduced for nursing and allied health professionals in the future.

On 30 and 31 October 2014, the Queensland Clinical Senate (QCS) met to discuss the key principles that would underpin governance of clinician performance measurement throughout the Queensland Public Hospital system.

The QCS does not engage in industrial issues. Very specifically, the QCS does not have any role in the development of specific performance measures.

The objective of the meeting was to have a frank conversation to:

- Demystify the issues around clinician performance measurement.
- Highlight performance measurement programs currently being utilised across some Hospital and Health Services (HHSs).
- Develop key governance principles to support its broad implementation.

Central to the debate was the key question of how performance should be measured to effectively demonstrate positive value not only to the patient but also to individual clinicians, HHSs and the health system as a whole.

Having considered the numerous challenges but also the potential advantages of embracing a culture of transparency of performance outcomes, the QCS strongly supports the importance of measuring clinician performance to achieve better outcomes for patients and improve accountability for the delivery and more effective use of health system resources.

Dr David Rosengren

**Chair**

**Queensland Clinical Senate**

26 November 2014

## Meeting Outcomes

- The QCS endorses measurement of clinician performance as an essential contributor to improving healthcare quality.
- To ensure that any performance measurement system achieves maximum impact on improving outcomes for patients, as well as clinicians and the HHSs that they work for, the QCS would expect:
  - a strong emphasis on clinician leadership and an opportunity for consumer input
  - a system that is driven by positive incentive rather than the fear of punitive action
  - a focus on quality outcomes rather than simple process measures
  - a model that is simple, meaningful and relevant, and which can evolve over time in response to the changing environment in which we practice
  - alignment of indicators with the strategic direction and priorities of the HHS.
- The QCS endorses the importance of clinicians being able to demonstrate consistent high standard of performance by use of a competency based evaluation framework and a commitment to professional development. The QCS however has strong concerns that a performance measurement system directed solely at the level of the individual clinician, limits the potential to drive local workplace performance improvement, let alone whole of health system improvement.
- With the expectation that performance measurement is directed at driving quality improvement, the QCS supports the development of a model that focuses on performance accountability at the work unit level. Demonstration of individual clinician competency through a process of performance appraisal does need to be one of the key elements of this model.
- The principles governing any performance measurement system must be consistent across the system but with the ability to be operationally individualised and contextualised to reflect local and professional discipline needs.
- Feedback needs to be objective, descriptive and timely, by peers who are aware of the key principles of adult learning.

**Work unit performance**

- The QCS overwhelmingly supports the following key principles as being critical to support performance measurement at the team/unit level:
  - Clear demonstration that performance measurement is championed at all levels within the organisation as a strategy to improve patient care through practitioner development.
  - An opportunity for clinicians to have an active role in determining methodologies and establishing benchmarks to support the relevance and validity of measures.
  - Ensuring sufficient financial, human and technological resources are available.

- Access to multiple assessment methods and quality data sources to ensure validity of reported outcomes.
- Guaranteed safeguard that identification and proactive management of the minority cases of unprofessional or impaired performance should continue in parallel.

Additionally, the QCS supports the importance of the following principles:

- Acknowledgement that attributes considered important by professional peers should be the targets for assessment.
- Utilising the many excellent performance measurement tools already in use across HHSs rather than unnecessarily 'reinventing the wheel'.
- Methods for assessing performance should be consistent across the system to support seamless assessment over a clinician's professional life time.
- Achieving high sampling rates for several different assessment methods to obtain a more accurate picture of overall performance.

**Individual clinician competency**

- The QCS strongly supports the development of core generic competencies that need to be assessed within individual performance appraisal for clinicians. These core competencies include:
  - Clinical expertise that is compassionate, appropriate and safe.
  - Effective clinical decision making in the management of complex clinical situations.
  - Effectively collaborates with clinicians and management alike and embraces multidisciplinary teamwork.
  - Ongoing commitment to learning, evaluation of clinical practice; and application of clinical knowledge and research.
  - Ongoing commitment to teaching.
  - Communication skills that support information sharing and emphasise shared decision making.
  - Professional and ethical behaviour and accountability to patients and the work unit.
  - Leadership as shown by high standards of practice and the promotion of quality focused system redesign.
  - Advocacy for the health concerns of patients and carers and demonstrating sensitivity to cultural, ethnic and spiritual needs.

## Recommendations

**The QCS recommends:**

- The Department of Health:
  - clearly communicate to all stakeholders the intent that measuring performance is directed at improving outcomes through a process of continuous performance improvement
  - endorse a performance measurement model, based on the principles outlined, that:
    - is directed and incentivised at the work unit level rather than being embedded within individual contracts
    - positively influences individual and work unit performance through a mixture of both achievable and also stretch targets
    - incorporates a balance of outcome, behavioural, competency and process-based criteria
    - promotes regular performance appraisal.
- Hospital and Health Services:
  - support the implementation of performance measurement models which are led by clinicians and have input from consumers
  - invest in the development and maintenance of competency in performance measurement, including individual clinician performance appraisal, for managers and leaders across all levels of the health system
  - ensure alignment between work unit performance measures and the strategic vision of the organisation.
- Clinicians:
  - led by the QCS, demonstrate leadership through promotion of a positive culture of accountability and quality improvement and a commitment to performance appraisal at the individual level and performance measurement at the work unit level.

## Appendix 1: Why measure performance?

Measurement is central to the concept of quality improvement. It provides a means to define what hospitals actually do, and to compare that with the original targets in order to identify opportunities for improvement. [1]

Clinical performance relates to what clinicians actually do in everyday professional practice.[2]

It is purported that comprehensive performance measurement can strengthen the health system. Improvement can be achieved by [3]:

- identifying areas of best practice
- focusing on continuous improvement
- delivering improved outcomes
- taking actions to improve health services
- ensuring that organisational activities are linked to overall strategy.

[1] World Health Organisation Regional Office for Europe's Health Evidence Network
[2] Scott I A, Phelps G, Brand C. Assessing individual clinical performance: a primer for physicians. Intern Med J 41 (2011)
[3] NHS Institute for Innovation and Improvement

# Appendix 2: Perspectives on performance measurement

## 2.1 Consumer perspectives on performance measurement

In recent times, models of 'consumer-centred care' have, and continue to be introduced which focus on healthcare that is respectful of, and responsive to, the preferences, needs and values of patients and consumers. There is strong evidence the involvement of consumers and placing them at the centre of care can lead to improvements in healthcare quality and outcomes by increasing safety, cost effectiveness and patient, family and staff satisfaction.

The importance of consumer input and consumer-centred care to the delivery of high quality healthcare is acknowledged through its inclusion in the *Australian Safety and Quality Framework for Healthcare* and *National Safety and Quality Health Service Standards (Standard 2).*

Patients, carers and consumers of health care in Queensland want high quality services which are affordable, accessible, equitable, based on best practice, safe, effective and improves health outcomes. Developing national measures of patient satisfaction and experience; improved reporting of health service level consumer experience; increased transparency and recognition that consumer experiences of the safety and quality of their health care should be a key measure of health system performance are strategies that should be considered in all modern and complex health systems.

Given a key objective of the introduction of clinician performance measurement is to drive quality improvement and improve patient outcomes, and acknowledging the important role consumer centred care has on safety and quality in healthcare, collaborating with consumers in the development of clinician performance measures is vital.

## 2.2 Clinician perspectives on performance measurement

The personal perspectives of clinicians and key stakeholders within the health system in Queensland were identified through a pre-meeting survey of members and guests and a panel discussion. Key points included:

- Clinician performance measurement provides an opportunity for alignment (system, organisation, teams and individuals) to achieve goals and objectives. This can only be realised if the culture and work environment stimulates innovation, communication is open, risks are being managed and teams are working towards common goals and objectives.
- Clinician performance measures must add value to patient, person and system outcomes. Only indicators that add value should be measured.
- Measures should encourage, motivate, recognise and reward behaviour that improves healthcare outcomes and service delivery across the system.
- Quality improvement requires strong clinical leadership. Improvement won't be realised if measures stifle good leadership and are viewed as a 'minimum standard of practice'.

- Performance measures should be set by clinicians in collaboration with management to ensure there is 'ownership' of the process and alignment of objectives.
- The introduction of performance measures is threatening for some clinicians. It has followed a series of reports perceived as critical of medical officers awards and practices and occurred simultaneously with the introduction of Senior Medical Officer (SMO) contracts. This has led to a perception that performance measures may be used as a punitive industrial tool.
- Good quality performance measurement tools and models are already in use (e.g. scorecards, 360% feedback). However there is a lack of trust in other tools, system wide processes and resources to collect and evaluate relevant and accurate data. This presents a risk that clinician's time will increasingly be spent supporting administrative processes to measure performance.
- Most clinicians perform at very high standard. A stronger focus on 'teams' and team performance will drive quality improvement.
- While performance measurement should be applied consistently across the system, there must be the capacity to individualise and contextualise it to reflect local and professional discipline needs.
- Risks to patient safety may arise if performance measurement is used to increase patient 'throughput' and meet targets.


Dr Denise MacGregor, Mr Ian Maynard, Ms Michelle Garner, Ms Brooke Cowie, Mr Ron Calvert, Mr Stephen McKernan

## Appendix 3: What does the research say about individual clinician performance?

A/Professor Ian Scott provided participants with the key findings following a literature review on the assessment of individual clinical performance. Important points included:

- Clinician performance relates to what clinicians actually do in everyday practice in professional practice (true behaviour influenced by individual and system factors). Competence relates to what clinicians can do in professional practice (in terms of knowledge skills and attitudes).
- Much of the literature relates to competence, not performance, with a strong focus medical students/residents/interns.
- Performance assessment may have several purposes (e.g. to maximise high value care, promote professional development, determine remuneration, identify poor performers). As the focus moves from the system to the individual, there is an increasing requirement for valid, specific and reliable performance measures.
- Over time, there has been a move from the predominate focus on technical clinical 'expertise' to include domains such as communication, leadership, diagnostic accuracy, care appropriateness and professional conduct.
- Measurement methods: implicit (intuitive ratings) vs. explicit (structured data to which specific criteria are applied), direct (evaluation of real practice) vs. indirect (assessment of skill in a contrived environment).
- Many tools and instruments have been developed to measure performance - most having been designed to measure specific performance attributes. Some tools measure almost all performance attributes (e.g. peer practice reviews and multisource feedback). Modern appraisal systems typically using a mixture of measurement tools.
- High quality measurement standards include: clinical relevance, scientific soundness of the measure; attribution accuracy and controllability (useful to determine if the measure outcome can be attributed to the behaviour of the individual concerned or the team behaviour), timeliness, metric balance, ease of use and no unintended adverse consequences.
- There is not a lot of evidence that existing tools actually measure clinician performance (i.e. what clinicians actually do). Mini-CEX measurement tool and Multisource feedback tools were identified as higher scoring measurement tools.
- While studies have identified mixed results for individual performance (practice) change, no studies have looked at the effects on patient care or outcomes.

- There is good evidence that audits and feedback can improve performance and surgical registries improve surgeon performance and more appropriate patient selection.
- Limitations of performance measures include:
    - Few studies of the long-term clinical impact and effectiveness of individual performance assessment.
    - Few measures of diagnostic error, overuse or inappropriate care, ability to manage complex multi-morbid patients with psychosocial issues.
    - Most measures do not capture other factors that impact outcomes (teamwork, leadership, innovation, culture).
    - Thresholds for determining adequate performance levels for process measures differ according to frequency of clinical condition, evidence base, psychometric properties, sampling rates.
    - The validity and reliability of many measures are questionable (e.g. issues around data accuracy, some processes have no relation to patient outcomes etc.).
    - Unintended effects (gaming, treating to the measure, opportunity costs, extrinsic motivation crowds out intrinsic motivation – especially for high level executive tasks, etc.) The strongest negative impact: measures contingent on very specific task performance (micromanagement) or associated with unrealistic targets, deadlines or sanctions).
    - Competing measures – conflicting aims and targets, good care vs. financial bottom-line.
- Recommendations for individual performance measures:
    - Develop a positive culture (constructive, not punitive).
    - Be clear about the purpose of performance measurement.
    - Ensure clinicians are involved in choosing assessment methods, adequately trained in the use of assessment methods and fully aware of their limitations.
    - Professional attributes regarded as important must be targets for assessment.
    - Multiple assessment methods using multiple data sources preferred.
    - High sampling rates for multiple less structured assessment methods gives the best picture of overall performance.
    - Sufficient resources and physician time to allow adequate collection and analysis of data, feedback and debriefing.

  - Combination of measurement feedback, reflection and mentoring helps – insightful practice.

- Future directions might include:
  - Move from measuring processes to outcomes.
  - Using performance measures strategically and dynamically to address contemporary care challenges and encourage innovation BUT give incentives/resources and make sure targets are specific, measurable, achievable, realistic and time limited.
  - Measure performance at the microsystem (department/unit level) rather than individual clinician (take KPIs out of individual contracts and into microsystem accountable care contracts).
  - Use aggregate measures that facilitate peer comparisons and maximise positive impact of professional competitiveness.
  - Use performance measurement to promote rapid-learning healthcare organisations.
  - Evaluate effects, applications, return on investment and adverse effects.
  - Standardise performance measures and methods of data collection, analysis and reporting across every HHS.

## Appendix 4: Applying clinician performance measurement – case studies and learnings

Participants were provided with an overview of several performance measurement programs in place in Queensland and lessons learned on their practical application.

Themes common to all case studies and perspectives included:

- Establishing a clear vision and objectives (through problem definition).
- Objectives for individuals, teams and organisations must align with system objectives.
- Governance - the workforce (clinicians) must be actively involved and lead the process.
- Communication with key stakeholders during all phases is critical. The use of language must be consistent.


Mr Scott Hartley, Dr Ian Coombes, Ms Veronica Casey, Dr Michael Daly, A/Professor Ian Scott

### 4.1 Senior medical performance review – Metro South Health

- Tool was first implemented in 2007 and is used as the basis to support the professional development of SMOs. Over 750 completed across Metro South HHS (>90% of eligible SMOs). Over 15,000 peer reviews completed. No breaches of confidentiality or grievances.
- SMPR completed every five years (costly to administer - time intensive for reviewers)
- Key attributes include: practicality, sustainability, spreadable.
- Objectives: safety and quality for patients, safeguards medical officers.
- Framework includes:
  - Profiling – e.g. qualifications, fellowships, registration details, credentials.
  - Clinical outcomes (objective data) – e.g. quality activities, complication rates, surgical infection rates, formal complaints, medico-legal issues, critical incidents, mortality rates, morbidity and mortality attendance.

  - Peer review – e.g. aggregated 360 degree peer review by colleagues (minimum of 12) on the categories of medical management and clinical acumen, team management, interpersonal interaction, ethics. Outcomes are benchmarked against medical colleagues and craft group.
  - Development plan – plan objectives (e.g. contribution of training and education, professional development and research).
- Intervention – when 360 degree feedback identifies the clinician is 3 standard deviations from the mean of their peer group.
- Approach to implementation – phased approach with key opinion leaders participating as the priority.
- Feedback on the tool varied however 68% said it would inform their practice.
- Framework is currently being reviewed. Modifications may include options to incorporate unit/specialty level data, review of SMPR objective and patient feedback.
- Advice for the QCS – be clear on the objective, hasten slowly, keep it simple, don't re-invent the wheel, recommendations need to be attainable.

## 4.2 Application of performance measurement for nurses

- The responsibility nurses have for the delivery of patient care in hospitals makes them well-equipped to record and evaluate performance measurement data
- Many standards and tools exist which guide and measure nursing care quality e.g. the Australian Council on Health Care Standards, Nurse Sensitive Indicators, Nurse Balanced Scorecards, Performance Appraisal and Development (PAD) processes
- The Magnet Recognition Program (MRP) is a key tool being used for the nursing service at Metro South HHS and has provided direction for the development of KPIs which support and align strategic nursing priorities and outcomes
- The MPR framework is an evidenced based, multidisciplinary, patient centric practice evaluation framework. Key elements include: transformation leadership, structural empowerment, exemplary professional practice, new knowledge, innovations and improvements.
- In addition to the MPR framework, all nursing staff employed at the Princess Alexandra Hospital, regardless of level, undergo a 360 degree self and peer review.
- Performance measurement must be instructive, informative and help clinicians to move forward – it must not be seen as being punitive.

## 4.3 Competency based performance evaluation feedback and development

- Pharmacy practitioner development in Australia incorporates the journey from intern training through to advanced practitioner and includes the attributes of education, research, management, relationships, leadership and practice.
- A general level framework is supported by work-based performance tools to create a portfolio of evidence. Work based performance tools include but are not limited to clinical evaluation tool [mini-CEX], team working evaluation [360 degree linked to PAD], KPIs, case discussion.
- Performance assessment allows 'gaps in practice' to be identified and action to be taken to improve outcomes.
- Factors critical to performance development success: assessment must be done well; it must not be seen as punitive.
- Competency frameworks support practitioner development:
  - Recognises consistent high quality performance
  - Supports the acquisition of skills via work based evaluation, feedback and development
  - Puts competence at the core of workforce development
  - Can support all practitioners in all areas
  - Supports life-long learning and return to work.

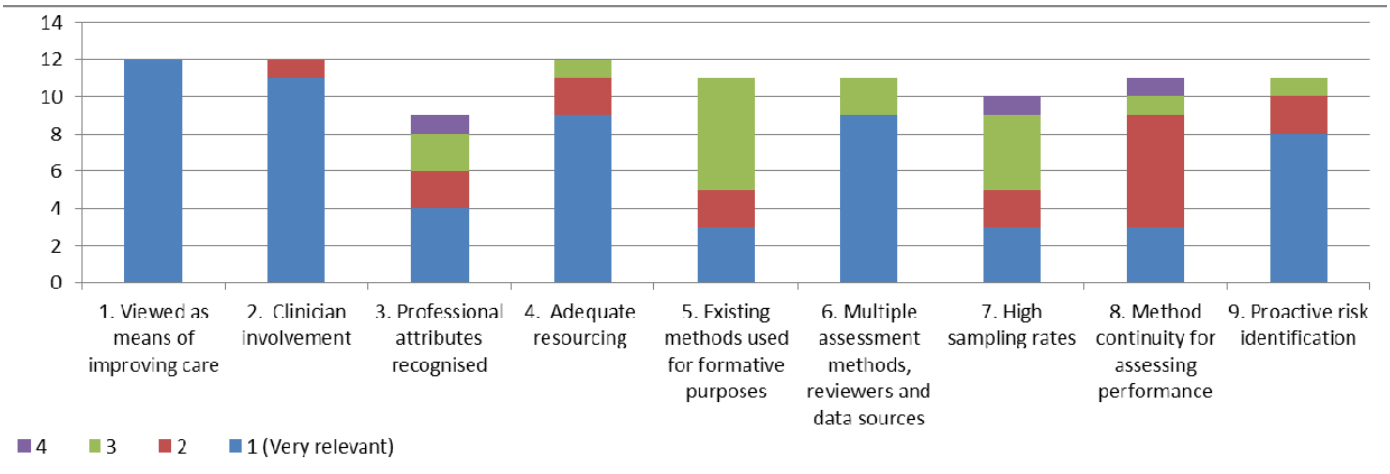
## 4.4 Lessons from Industry

- Performance measurement is one element of a broader governance framework. Elements such as culture, legislative compliance, continuity of care, priorities and strategies etc. must also be considered.
- Successful performance measurement and engagement requires by-in to the strategic objectives. Measures need to be linked to achievement of strategic objectives.
- Measures don't drive required behaviour/culture. Measures should reflect the culture you are driving (e.g. to create a culture of collaboration – recognise and reward team performance).
- Influence and evidence - there must be a clear link between individual performance and outcome and robust evidence to support it.
- People will focus on what's measured – be conscious of unintended consequences.

## Appendix 5: Factors critical to success

Participants were asked to review nine factors identified as critical to success in performance assessment programs (Scott IA et al, Appendix 1). Groups rated the relevance of the factors using a five point Likert scale (1 very relevant -> 5 not relevant) and identified the following five factors as most relevant:

- Performance assessment needs to be viewed as a means for assessing and potentially improving patient care across the board, not as a potentially punitive exercise aimed solely at a very small minority of poorly performing individuals.
- Clinicians need to be actively involved in choosing assessment methods and specifying performance benchmarks, be adequately trained in the use of assessment methods, and be fully aware of their limitations.
- Sufficient resources and physician time must be made available to allow adequate collection and analysis of data, feedback and debriefing involving those being assessed, and input of assessment results into ongoing individual learning portfolios and professional development plans. As much as possible, assessment methods must not be unduly burdensome and use information and data that clinicians already collect, or can collect in the future with a minimum of effort and expense.
- Multiple assessment methods involving multiple reviewers and a variety of data sources are preferred to a single or a small number of methods and or data sources in order to overcome the respective problems of content for skill specificity and bias or inaccuracy involving data sources.
- The proactive identification of the relatively few cases of behaviours which are clearly unprofessional or suggest grossly impaired performance should continue in parallel with the evolving implementation of more refined methods of performance assessment.



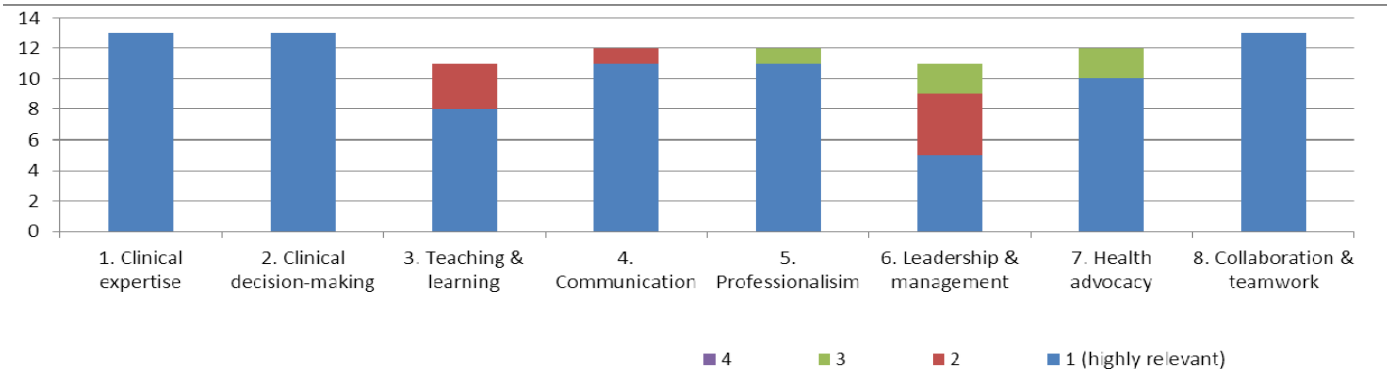
Participants agreed that the nine measures described by Scott et al could be used as principles going forward and recommended the following factors be considered for inclusion also:

- Involvement of consumers - the incorporation of patient feedback and experience at all levels.
- The inclusion of unit/team performance measures in addition to measures focused on the individual clinician.
- Measures must be relevant and consistent across the system and across disciplines with the ability to be individualised and contextualised to reflect local and professional discipline needs.
- Measurement of consistency of performance in non/technical areas.

## Appendix 6: Generic clinician competencies

Participants were asked to review eight performance attributes (adapted from the framework of the Royal Australasian College of Surgeons by Scott et al, Appendix 2) to determine if they could be used as generic multidisciplinary system measures. Groups rated the relevance of the attributes using a five point Likert scale (1 highly relevant -> 5 less relevant) and while there was strong support for all attributes, groups unanimously identified the following three factors as highly relevant:

- Clinical expertise: integrating and applying knowledge, skills and attitudes in the provision of patient care that is compassionate, appropriate, safe and effective.
- Clinical decision making: applying effective forms of reasoning in the diagnosis, management and prognostication of complex clinical situations
- Collaboration and teamwork: demonstrating skills in exchanging information, establishing shared understandings and playing an active role in clinical teams.




Eight out of 10 groups agreed that the attributes described by Scott et al could be used as the basis for a generic multidisciplinary framework going forward.

Other generic attributes identified for consideration by the groups included:

- shared decision making
- research (as a separate attribute where appropriate)
- strengthening 'teaching' component of the 'teaching and learning", and
- strengthening the description of the "leadership and management" attribute to include mentoring, positive role modelling and efficiency.

Generic competencies should be used in conjunction with existing tools to support self-assessment and peer review. They should be supported by: descriptive feedback, structured development tools to enable objective performance assessment, gap identification and a plan to up-skill/address gaps. Tools will need to be contextualised to reflect the experience level of the clinician and working environment.

## Appendix 7: Critical Success factors survey tool

1. **IMPROVING CARE** - Performance assessment needs to be viewed as a means for assessing and potentially improving patient care across the board, not as a potentially punitive exercise aimed solely at a very small minority of poorly performing individuals. (very relevant) *1 2 3 4 5* (not relevant)

2. **INVOLVE CLINICIANS** - Clinicians need to be actively involved in choosing assessment methods and specifying performance benchmarks, be adequately trained in the use of assessment methods and be fully aware of their limitations. (very relevant) *1 2 3 4 5* (not relevant)

3. **RECOGNISED ATTRIBUTES** - The professional attributes regarded as important must be the targets for assessment, even though this may pose methodological challenges for many assessment instruments. (very relevant) *1 2 3 4 5* (not relevant)

4. **ADEQUATE RESOURCING** - Sufficient resources and clinician time must be made available to allow adequate collection and analysis of data, feedback and debriefing involving those being assessed, and input of assessment results into ongoing individual learning portfolios and professional development plans. As much as possible, assessment methods must not be unduly burdensome and use information and data that clinicians already collect, or can collect in the future with a minimum of effort and expense. (very relevant) *1 2 3 4 5* (not relevant)

5. **EXISTING METHODS** - Currently available assessment methods should be used for formative purposes (professional development and improvement) rather than summative purposes (recertification) until they attract more robust evidence of validity and reliability. (very relevant) *1 2 3 4 5* (not relevant)

6. **MULTIPLE METHODS** - Multiple assessment methods involving multiple reviewers and a variety of data sources are preferred to single or a small number of methods and/or data sources in order to overcome the respective problems of content (or skill) specificity and bias or inaccuracy involving data sources. (very relevant) *1 2 3 4 5* (not relevant)

7. **HIGH SAMPLING** - Achieving high sampling rates for several different assessment methods, even if they are not highly standardised, probably gives a more accurate picture of overall performance than relying on a small number of methods which, while highly standardised and reliable, are associated with lower rates of sampling. (very relevant) *1 2 3 4 5* (not relevant)

8. **METHOD CONTINUITY** - Methods for assessing performance applied should be similar in format, coverage of behaviours and means of application in order to create a seamless, continuous line of assessment throughout professional life. (very relevant) *1 2 3 4 5* (not relevant)

9. **RISK IDENTIFICATION -** The proactive identification of the relatively few cases of behaviours which are clearly unprofessional or suggest grossly impaired performance should continue in parallel with the evolving implementation of more refined methods of performance assessment. (very relevant) 1 2 3 4 5 (not relevant)

Adapted from Scott I A, Phelps G, Brand C. Assessing individual clinical performance: a primer for physicians Intern Med J 2011; **41**: 144 – 55

## Appendix 8: Generic clinician competences

1. **CLINICAL EXPERTISE** – Integrating and applying knowledge, skills and attitudes in the provision of patient care that is compassionate, appropriate, safe and effective. (Technical expertise, defined as the safe and effective performance of invasive procedures may be a sub-competency that is more relevant to specific professional groups and specialties). (highly relevant) *1 2 3 4 5* (less relevant)

2. **CLINICAL DECISION-MAKING** – Applying effective forms of reasoning in the diagnosis, management and prognostication of complex clinical situations. (highly relevant) *1 2 3 4 5* (less relevant)

3. **TEACHING AND LEARNING** – Demonstrating an ongoing commitment to self-directed, reflective and experiential learning, evaluation of clinical practice, and generation, dissemination, and application of medical knowledge and scientific research. (highly relevant) *1 2 3 4 5* (less relevant)

4. **COMMUNICATION** – Communicating effectively with patients, families, carers, colleagues, healthcare teams, and the broader community in relation to care needs of individual patients and whole populations. (highly relevant) *1 2 3 4 5* (less relevant)

5. **PROFESSIONALISM** – Demonstrating ethical behaviour, self-reflection and insight into one's limitations (both cognitive ability and physical health), and accountability to patients, the profession and society. (highly relevant) *1 2 3 4 5* (less relevant)

6. **LEADERSHIP AND MANAGEMENT** – Setting and demonstrating high standards of practice, and promoting system redesign that renders care safer and of higher quality. (highly relevant) *1 2 3 4 5* (less relevant)

7. **HEALTH ADVOCACY** – Responding to the health concerns of individual patients, families, carers and communities and demonstrating sensitivity to cultural, ethnic and spiritual needs. (highly relevant) *1 2 3 4 5* (less relevant)

8. **COLLABORATION AND TEAMWORK** – Demonstrating skills in exchanging information, establishing shared understandings and playing an active role in clinical teams. (highly relevant) *1 2 3 4 5* (less relevant)

Adapted from - Scott I A, Phelps G, Brand C. Assessing individual clinical performance: a primer for physicians *Intern Med J* 2011; **41**: 144 - 55