CFEP SURVEYS

Comprehensive Guide to Multi-Source Feedback (MSF)

Client Focused Evaluation Program (CFEP) Surveys is committed to supporting reconciliation among Indigenous, Aboriginal and Torres Strait Islander peoples and non-Indigenous Australian people.

We acknowledge the Aboriginal and Torres Strait Islander peoples as the Traditional Custodians of the lands and waters. We pay respect to Elders – past, present and emerging, and acknowledge the important role Aboriginal and Torres Strait Islander peoples continue to play within our community.

CFEP SURVEYS

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A quick guide for clinicians undertaking multi-source feedback (MSF) to improve their professional and interpersonal performance, and for health services, hospitals, medical colleges and CPD homes offering MSF as a professional development program

The MSF supporting guide

A detailed look at MSF and the evidence supporting it, its links to continuous quality improvement, the Quadruple Aim of health care, the Medical Board of Australia's Professional Performance Framework, and how to implement MSF in a range of healthcare organisations

The MSF fast guide

Fast facts

- **MSF gives a 360-degree view of professional performance.**
- **MSF is ideal for use across a doctors career span.**
- **MSF has wide-reaching benefits across the entire health system.**
- **MSF contributes significantly to clinicians' continuing professional development.**
- **CFEP Surveys offers a market-leading MSF tool.**
- **The MSF tool has 3 parts: patient assessment, colleague assessment, self-assessment.**
- **MSF involves 3 participant types: clinician, patients and colleagues (reviewers), debriefer (a coach or supervisor who provides a formal debrief), the supporting medical colleague (SMC).**
- **The MSF process spans 4 stages: data collection, analysis and reporting, debrief and self-reflection, action planning and CPD allocation.**
- **Organisations offering MSF as a professional development program need a robust implementation plan.**
- **MSF should be revisited annually in line with the Medical Board of Australia Professional Performance Framework.**

MSF gives a 360-degree view of clinician performance

Multi-source feedback or MSF is an evidence-based professional development tool for doctors of all specialties.

Clinicians use MSF to collect objective, specific feedback from their patients and clinical and non-clinical colleagues to gain a 360-degree perspective of their performance. It's sometimes called 360 feedback.

MSF is a powerful tool for generating insights into professionalism and practice. It's an opportunity for evidence-based refection to identify strengths and improvement areas.

MSF works towards the Quadruple Aim of health care and value-based health care. It helps drive continuous, data-driven quality improvement so clinicians can work at the top of their scope and help achieve high-performing health care nationally.

MSF qualifies as continuing professional development (CPD) hours, and aligns with the Medical Board of Australia's new Professional Performance Framework.[1]

Clinicians and organisations participate in MSF

Clinicians – MSF candidates

- Use MSF as an objective approach to professional development, growth and improvement
- Use MSF to reflect on your role as communicator, collaborator and professional to become an even better clinician
- Receive continuing professional development hours with medical colleges and peak bodies nationally

Figure 1: MSF tool domains, roles and definitions.
Source: Developed by CFEP Surveys, 2021.

Organisations – medical colleges, CPD homes, hospitals and health services offering MSF

- Support your membership to meet requirements under the Medical Board of Australia's Professional Development Framework from 2023, and industry regulations
- Provide a robust, internationally validated and evidence-based MSF tool for clinician and non-clinician quality programs
- Help create a culture of collaboration, communication, trust and excellence among clinical cohorts
- Help strengthen and embed evidence-informed professional development and continuous quality improvement into ongoing professional practice

CFEP Surveys offers a market-leading MSF tool

The CFEP Surveys MSF tool is a robust, internationally validated and evidence-based MSF program.

The CFEP Surveys MSF tool is available to any health care professional operating in any sector within the Australian healthcare system. Variations are available for some specialties and their medical colleges.

A non-clinical MSF tool is also available, to support organisations with a whole-of-practice approach to quality improvement that engages all members of the practice or care delivery team.

CFEP Surveys MSF tool includes:

- access to a **secure online portal** to streamline data collection and reporting and maintain privacy and confidentiality
- **personalised support** to limit the administrative burden on clinicians
- comprehensive, **insightful and easy-to-follow reports** to support self-reflection and highlight improvement areas for improvement
- **comprehensive benchmarking data** to compare performance to national averages
- a **complementary reporting interpretive guide,** and the option of a formal review.

For more information about CFEP Surveys services, see: **cfepsurveys.com.au**

MSF has wide-reaching benefits

Clinician

- A true professional development exercise
- Interpersonal and professional skills development
- CPD hours to meet annual professional development requirements
- Stronger professional and personal support networks
- Stronger professional standing and reputation
- Deeper trust from your medical college and professional network
- A great pulse check in a changing health landscape

Patients

- A greater voice in health care
- A stronger partnership in health care
- Acknowledgement of the patient experience
- A chance to directly improve patient care
- Greater trust in providers, and greater engagement and activation in care

Healthcare organisations including medical colleges and CPD homes

- An evidence-based tool that supports clinical cohorts
- Additional rigour to a cohort's professional performance and reputation
- Evidence of quality improvement in micro, meso and macro systems and processes
- Encouragement for clinical cohorts to continually seek improvement in their own service delivery
- Confidence in a validated, 'fit-for-purpose' MSF tool and associated reflective exercise and peer support elements
- A full-service model from CFEP Surveys

Health system

- Clinicians who are better informed and more likely to work at the top of their scope, supporting superior service delivery across the system
- Stronger collegiate relationships and networks, creating a more robust system where more information is shared and fewer risks exist because clinicians are more likely to consult a colleague as a result of the trust developed during the MSF process
- Support for the person-centred approach to health care, in line with the national move towards person-centred, integrated, value-based care
- A standard and validated MSF tool that reduces variability of feedback and increases the value of the reflective and peer support processes – quality measures, delivered in a supportive standardised way
- Potential cost savings from improved clinical service delivery – a more engaged, more agile clinical cohort, more responsive to patient need

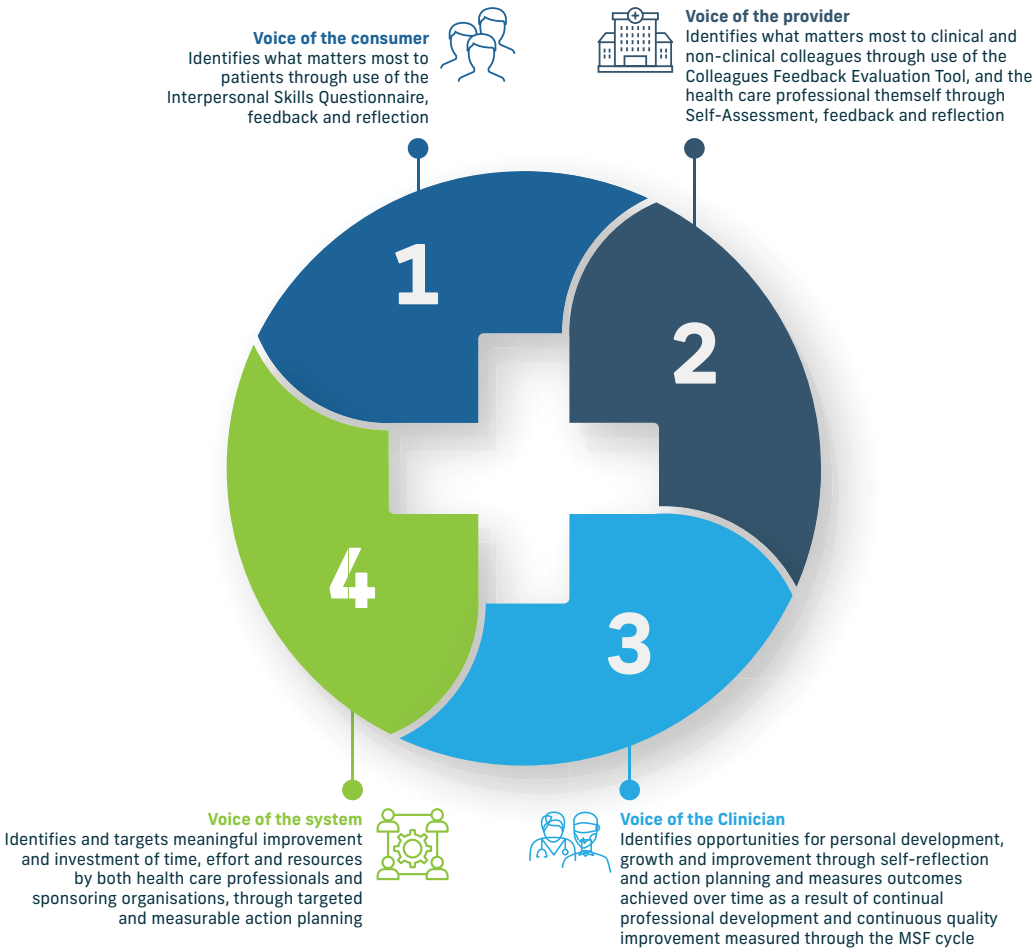

Figure 2: Quadruple Aim and MSF.[2,3]
Source: Adapted by CFEP Surveys, 2022.

The CFEP Surveys MSF tool has three parts

The MSF tool (and its variants) comprises three evidence-based instruments which assess each of the three roles clinicians undertake: collaborator, communicator, professional.

Each instrument is based on observable behaviours of health care professionals.

The three instruments in the MSF tool are:

1. **Interpersonal Skills Questionnaire (ISQ)**
   – ***What is my patient's experience of care?***

2. **Colleague Feedback Evaluation Tool (CFET)**
   – ***How am I perceived by my colleagues?***

3. **Self-Assessment (SA)**
   – ***Do I see myself as others see me?***

A combined assessment of the three roles a clinician plays gives a rounded perspective on their performance, and identifies key strengths and areas for professional development, personal growth and improvement in practice.

See the MSF supporting guide for a closer look at the CFEP Surveys MSF tool.

MSF involves four participant types

MSF candidate	• Undertakes, MSF either independently, or as a part of their training program through a medical college or CPD home, or perhaps as a part of a workplace program • Undertakes the MSF process for professional development and a 360-degree of their performance across their roles as communicator, collaborator and professional • Nominates their colleague reviewers and debriefer (and/or supporting medical colleague (SMC) • Completes the Self-Assessment instrument of the MSF tool
Reviewers (patients and clinical and non-clinical colleagues)	• Provides objective feedback about an MSF candidates observable behaviours • If a colleague, is nominated by the MSF candidate and can be a clinical colleague or non-clinical co-worker who has worked with the MSF candidate in the past one to two years • Can be a patient who has experienced clinical care from the MSF candidate
Debriefer	• Holds a coaching conversation with the MSF candidate about the MSF feedback once the report is received by the candidate • This can be delivered by a CFEP Surveys coach, a medical educator (ME), a supervisor, or another formal coaching style role • Helps the candidate consider the multiple data sources they receive, identify strengths and opportunities for improvement, and develop an objective and evidence-informed action plan outlining actions for personal development, growth and improvement
Supporting medical colleague (SMC)	• Provides an informal debrief or support to the candidate when they're conducting their formal debrief (as described above) to help the candidate reflect on strengths and opportunities for improvement, and when the candidate is planning for change

The MSF process has four stages

STAGE 1

Objective and meaningful data collection comprising patient feedback, colleague feedback and Self-Assessment

STAGE 2

Analysis and reporting resulting in feedback of the assessment data and comparators as appropriate

STAGE 3

Debrief and self-reflection to identify learnings, opportunities and priorities for professional development, growth and improvement

STAGE 4

Action planning and CPD allocation which translates results into action

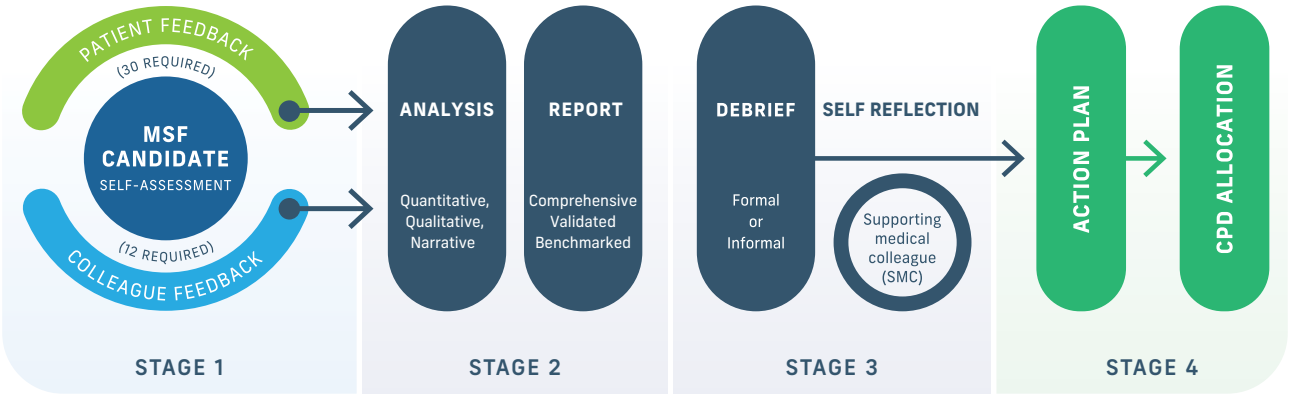

Figure 3: CFEP Surveys MSF process.
Source: Developed by CFEP Surveys, 2021.

STAGE 1

1. The candidate selects their colleague reviewers and advises CFEP Surveys. CFEP Surveys guides the MSF candidate, if required, when they're identifying their reviewers.
2. CFEP Surveys invites the candidate to nominate a supporting medical colleague (SMC).
3. A patient feedback pack (digital recommended) is issued, to be administered by the candidates practice or administration support team (to a sample of the candidates patients).
4. The candidate completes the Self-Assessment survey.
5. The reviewers complete either the Interpersonal Skills Questionnaire (patient) or the Colleague Feedback Evaluation Tool (colleague).

STAGE 2

1. CFEP Surveys receives a candidates data and analyses it by source (i.e. patient or colleague).
2. If the candidate is using the full MSF tool, CFEP Surveys will give the candidate a comprehensive MSF report. If the candidate is using only part of the MSF tool, CFEP Surveys will give the candidate either the patient feedback report or the colleague feedback report.
3. CFEP Surveys gives complementary written guidance on how to:
   - interpret and make the most of the report
   - reflect on strengths and areas for professional and practice improvement (professional development, growth and improvement)
   - next steps and how to use results to plan for change (action planning).

STAGE 3

1. Within one week of the report being received by the candidate, a debrief is held to review the data and discuss the results. Debrief can be formal (with CFEP Surveys), or informal with their own nominated person (the SMC, a medical educator, supervisor or similar).

2. The candidate undergoes self-reflection to help them prioritise areas for professional development, growth and improvement and develop the action plan.

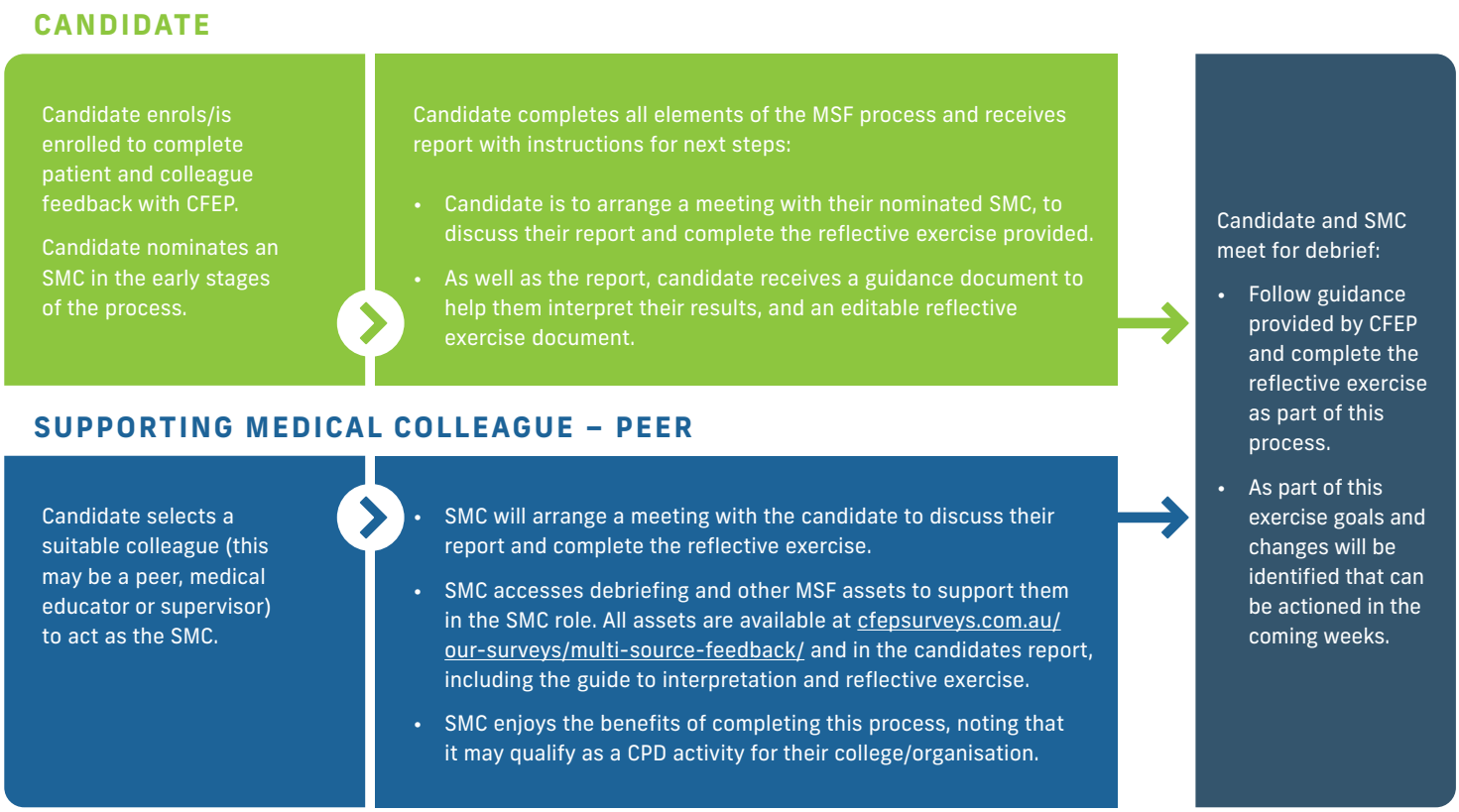

Figure 4: MSF informal debrief and self-reflection process.
Source: Developed by CFEP Surveys, 2022.

STAGE 4

1. The candidate and their SMC co-develop goals for the candidate's professional development, growth and improvement, and an evidence-informed action plan.
2. The candidate and the SMC may hold a (highly recommended) follow-up session one to two months after they have developed the action plan, to reflect on the impact of short-term change.
3. CFEP Surveys gives the candidate a certificate of completion for CPD purposes.
4. The candidate applies for CPD hours with the relevant organisation.
5. CFEP Surveys invites the candidate to review their MSF process annually.

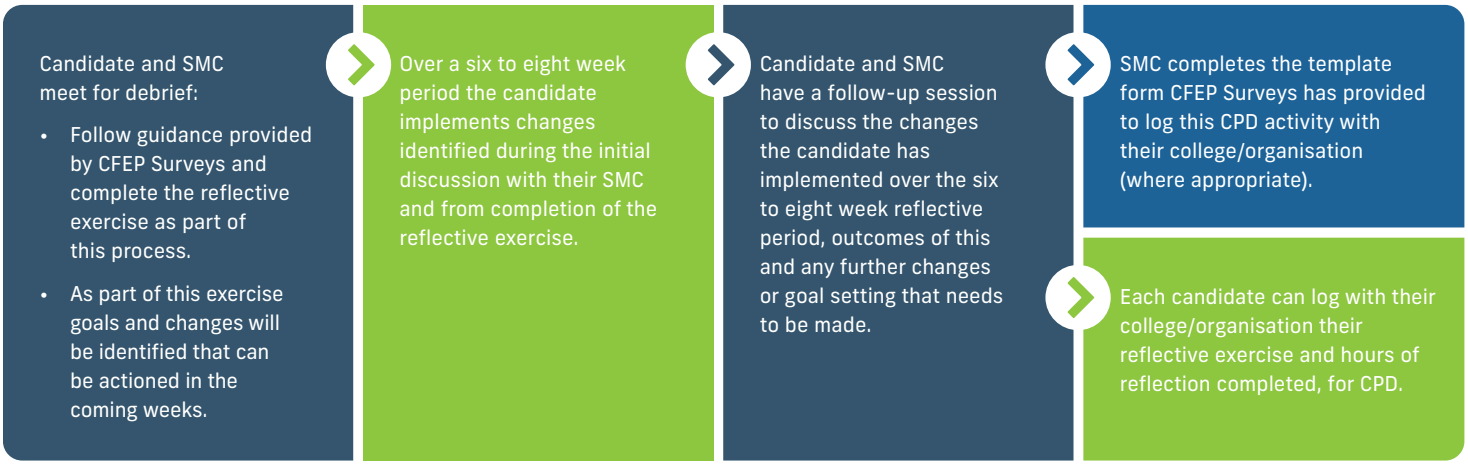

Figure 5: MSF action planning process and CPD allocation.[4-7]
© CFEP Surveys

Process guide for Multi-Source feedback, including patient (ISQ) and colleague feedback (CFET) components

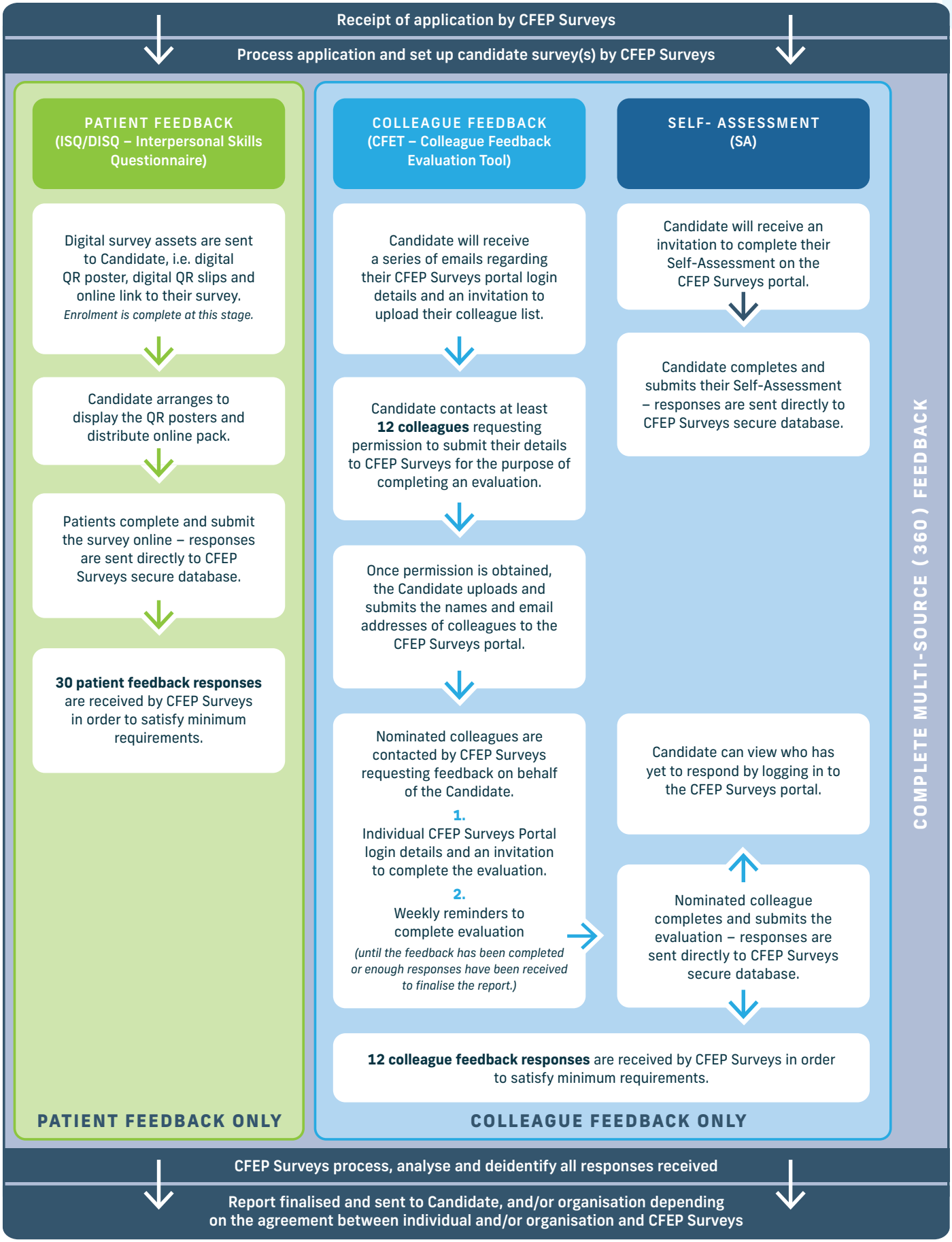

Figure 6: Process for the distribution and collation of the MSF tool instruments.
Source: Developed by CFEP Surveys, 2022.

More information about each stage is in the supporting guide.

Organisations need a robust MSF implementation plan

Introducing MSF and applying the MSF tool requires organisational commitment and resourcing. Developing a robust implementation plan with a feasible timeline supported by an effective engagement and communication plan is essential for success.[5,8]

The process demands both clinical and non-clinical leadership for making decisions about implementing the program, maintaining it, and evaluating and monitoring it.

Key considerations when introducing the MSF program to any organisation are shown in Table 1.

Considerations	Implementation strategies
Create organisational readiness	Secure funding for the entire MSF program. Develop MSF champions (i.e. clinical, non-clinical, and consumer) who will promote, socialise and support MSF program start-up and implementation.
Establish organisational and program support and buy-in	Commit to: • leadership (i.e. clinical and managerial) engendering a culture of excellence, patient safety and CQI • leadership creating, promoting, and sustaining the MSF program • reviewers (i.e. clinicians, non-clinical co-workers and patients) engaging in providing constructive and timely feedback • MSF candidates giving considered feedback, carefully reviewing the data and results, and engaging in discussions to create an evidence-informed action plan. Put in place a plan, and allocate funding, to appoint or train facilitators or coaches to conduct informal debriefing activity and work with MSF candidates to develop and review action plans. Alternatively, secure funding to encompass CFEP Surveys formal debriefing service provided by trained MSF facilitators or coaches. Allocate sufficient technology and human resources during program start-up and delivery, noting this resource may reduce over time as MSF is normalised within professional or organisational developmental processes.
Approve or facilitate CPD recognition	Recognise that clinicians or organisations choose to use MSF need to secure CPD recognition for the program. If you are a CPD Home or CPD Approving body, ensure suitable recognition of hours is in place.
Establish the MSF program team	Establish a small action-oriented program team to lead the introduction of MSF and sustain it over time. It should include members of: • the leadership team (i.e. clinical and managerial) • the organisation's learning and development team and those who will administer the program • change champion representatives (i.e. clinical and non-clinical) • representatives of the cohorts of clinicians who will be assessed (i.e. potential candidates) and those who will support them (i.e. potential supporting medical colleagues).

Considerations	Implementation strategies
Determine how the results will be used and who will have access to them	Make clear to all potential participants (candidates, reviewers and SMCs) how data will be used if they choose to apply MSF in ways other than intended (e.g. to inform summative decisions). Have an organisational plan in place to deal with egregious behaviour if it is identified (e.g. a person exposing data).
Identify candidates and reviewers and schedule engagement	Consider financial and human resources so you can offer the MSF program. Determine how many people you can support in any given period. It is important to ensure all clinicians have the opportunity to participate in the MSF program, but financial and human resources will need to be considered to determine what numbers are feasible in a given cycle.
Agree how frequently MSF will be conducted	Be aware that the Medical Board of Australia's Professional Performance Framework promotes an annual cycle of review, reflection, professional development, growth and improvement. The MSF tool (completed in full or part) supports this professional requirement. This 12-month cycle allows sufficient time for clinicians to action and demonstrate outcomes related to changes they have made in interpersonal skills and professionalism and their communicator, collaborator, professional roles. If this assessment is completed beyond this 12-month cycle, the MSF candidate may be unable to demonstrate outcomes and improvement over time, or develop timeous evidence-informed action plans for personal development, growth or improvement.
Determine the process for facilitated feedback, coaching, supported action planning and review	Identify resources for the required feedback conversation with a trained facilitator or coach who helps candidates interpret their data, determine ways to improve, and develop an action plan. As a minimum, determine whether you would like CFEP Surveys to give the candidate and SMC, supervisor or medical educator a standardised protocol to aide debrief and action planning discussions. Alternatively, identify trained staff within the organisation who can undertake this activity. For example, in some organisations, a departmental or division head may be responsible for having these discussions. Optimally, use CFEP Surveys trained and experienced coaches for the formal debrief. Note criteria for the success of the facilitated feedback and coaching conversation include: • ensuring processes and practices protect the anonymity of reviewers and confidentiality of the facilitated feedback, coaching and supported action planning processes • adopting a dialogic and inquiry approach, and conducting the debrief conversation respectfully and empathetically in a safe and non-threatening environment • encouraging the candidate to identify personalised development, growth and improvement strategies they can confidently implement, rather than adopting an advocacy approach and suggesting strategies or solutions.

Considerations	Implementation strategies
Recruit and prepare facilitators/coaches	Recruit and prepare the facilitator or coach, understanding that they play a critical role in conducting a robust and evidence-informed debrief and reflective feedback discussion and that the data may be challenging for the candidate and the nominated facilitator or coach at times. Note specific activities include: • developing a trusting relationship • exploring the candidate's reactions to the report and the data • encouraging reflection and self-critique • ensuring the candidate understands what the data mean to them and their professional practice • helping to identify strengths, opportunities for improvement and the selection of one or more priorities for action • co-developing an action plan to identify goals and address developmental needs • identifying/offering resources to help execute the plan • (and, throughout the process) supporting the candidate's informed Self-Assessment and self-directed learning approaches to enable effective, lifelong learning. Professional facilitation/coaching is a recognised leadership skill that is transferable across all health care professions, settings and situations. CFEP Surveys offers training services to organisations in which a group of internal facilitators or coaches may be trained and supported to participate in debrief and action planning discussions. For more information, contact the CFEP Surveys team.
System learning and continuous improvement	Adopt a learning system and CQI (e.g. implementing improvements to engagement and communications strategies via PDSA cycles) process for MSF implementation. Monitor and review the MSF program to successfully embed it in both health care professional and organisational development processes as business as usual.

Table 1: Considerations when implementing MSF.
Source: Developed by CFEP Surveys, 2022.

MSF process guide for organisations

The following outlines the process organisations adopt when implementing MSF:

Figure 7: MSF process guide for organisations.
Source: Developed by CFEP Surveys, 2022.

Note: This process chart assumes both digital and paper surveys are utilised for patient feedback, however digital administration is the recommended and more popular mode.

The MSF supporting guide

MSF is an important professional development process

MSF systems are deeply established in industry[9], with 360-degree type feedback routinely used as a workplace assessment tool to:

- develop insights into individual strengths and opportunities for improvement
- enhance cultural change
- produce summative assessment of performance
- evaluate potential (e.g. careers advice or selection)
- enhance team effectiveness
- identify training needs for the organisation.[10]

Original work on the development of MSF tools for physicians was undertaken in the United States[11,12] and later developed over several years by the College of Physicians and Surgeons of Alberta's (CPSA) Physician Achievement Review (PAR) program[13], and the Medical College of Canada.[14,15]

MSF is increasingly adopted within continuing professional development and regulatory frameworks worldwide as a method to assess medical performance and quality-assure clinical practice.[16] The validity evidence for MSF used within medicine is well established, and MSF is now used in health systems across Canada, Australia, the Netherlands, New Zealand, the United Kingdom, and the United States, with interest growing in other countries.

> ***'When done in the right way for the right purpose, MSF systems have been shown to enhance teamworking, productivity, communication and trust.'[10]***

> ***'Multi-source feedback (MSF) has become the accepted mechanism of ensuring the appropriate professional behaviour of doctors.'[10]***

The MSF program combines quantitative and qualitative data, narrative comments, and dedicated debrief and coaching time with a trained facilitator or coach. These elements are then used to develop an objective and constructive action plan that informs personal development, growth and improvement.

Leveraging CFEP Surveys expertise in practice assessment, **the MSF program aims to normalise the process of professional review and reflection as part of a supportive whole-system learning approach** encompassing professional bodies, provider organisations, and health care professionals.

CFEP Surveys MSF tool provides an annual cyclical process of reviewing performance, measuring outcomes, and self-evaluation. After completing the action plan, CFEP Surveys recommends candidates repeat the virtuous cycle of MSF to engender a culture of excellence, demonstrate leadership, and sustain their lifelong learning and improvement journey.

Good communication and collaborative skills handled professionally are the foundations of safe and quality care at the micro system level (the frontline of care).[17] Poor communication with patients, clinical colleagues or non-clinical co-workers, and unprofessional behaviour, can negatively impact effective team-based care, patient experiences of care and health outcomes and, in turn, the value of health care provision. For example, poorly written referral letters may result in delays while referral appointments are triaged or unnecessary duplicate investigations are pursued. Likewise, a lack of or poorly coordinated team discussions about patient needs, goals of care, shared care planning and so on can negatively impact patient access to the right care, by the right provider, at the right time and cost.

Similarly, a clinician who provides inadequate explanations to patients or doesn't correctly pitch their conversations to the patient's level of health literacy[18] or activation[19] may affect how well the patient complies with treatment or care plans or adheres to the medication regimen. This may result in poorer health outcomes and increased disutility of care, such as repeat visits, follow-ups with other clinicians, avoidable emergency department presentations or potentially preventable hospitalisations.

Recognising the importance of feedback about patient interactions, professional behaviours and performance in practice[8], the MSF tool supports individual health care professionals to:

- capture unique performance data about their interpersonal skills (communicator and collaborator roles) and professionalism (professional role)
- recognise their three roles are best assessed by those who regularly work with them, observe them in practice, and interact with them
- collect a balanced source of objective data from those working with them (i.e. clinical colleagues, non-clinical co-workers, and patients).

Role	Description
Communicator	Effective communication is central to patient safety and quality and the delivery of a person-centred care approach focused on patient/clinician partnership, patient activation and engagement, and optimal health outcomes. Clinicians enable effective communication by exploring symptoms and actively listening to the patient's story and condition-related experiences. They explore the patient's perspective, including concerns and fears, ideas and feelings about the impact of their condition, and expectations of health care and health care professionals. The clinician assimilates this knowledge (together with an understanding of the patient's context including socio-economic status, medical history, family history, stage of life, living situation, work or school setting, and other relevant psychological and social issues) and engages the patient in shared decision-making processes. This includes finding common ground with the patient to develop an evidence-informed plan or guidelines-informed cycle of care to address their clinical condition and health goals in a manner that reflects the patient's needs, values, and preferences. Since illness affects not only patients but also their families, clinicians must be able to communicate effectively with everyone involved in the patient's care.
Collaborator	Collaboration involves patients and their family and carers, clinicians and other clinical and non-clinical colleagues, other health system and community partners in the delivery of safe, high quality, patient-centred care. It requires relationships based on mutual respect and trust, and shared decision-making among various people across multiple settings spanning the patient's personal web of care and care continuum. Collaboration builds on effective communication and involves sharing knowledge, perspectives and responsibilities and being willing to learn together. This requires an understanding of others' roles, pursuing common goals of care and better health outcomes, and managing differences. Skills associated with effective collaboration include activities beyond clinical care, such as administration, education, advocacy, and scholarship.
Professional	All clinicians serve an essential societal role as professionals dedicated to the health and care of others. Their work requires mastery of the art, science, and practice of medicine. A clinician's professional identity is central to this role. The role reflects society's expectations of clinicians, including that they possess clinical competence, are committed to continuing professional development, promote the public good, adhere to ethical standards and values such as integrity, honesty, altruism, humility, respect for diversity, and show transparency around potential conflicts of interest. In addition, it is acknowledged that clinicians must take responsibility for their own health and wellbeing and that of their colleagues. Professionalism is the basis of the implicit contract between society and health care professionals, conceding self-regulation by the Australian Health Practitioner Regulation Authority (AHPRA) with the understanding that clinicians are accountable to those they serve, society, themselves and their profession.

Table 2: MSF role descriptions.[20]
Source: Adapted by CFEP Surveys, 2022.

Substantial evidence supports MSF

While the content of the MSF instruments – the Interpersonal Skills Questionnaire, the Colleague Feedback Evaluation Tool and the Self-Assessment – may appear to be relatively simple, there is a substantial amount of research, time, money and effort invested in producing these 'fit-for-purpose' tools. For example, in the United Kingdom, the General Medical Council committed over GBP500,000 to ensure the tools used for their MSF program were robust, reliable and validated so data was meaningful for doctors.

A wide range of research has been conducted on the use of MSF internationally in various clinical settings. A review of eight systematic reviews demonstrated the evidence base supporting the statistical and psychometric properties of MSF is sufficient to support using the validated tool in the clinical setting.[16] The structural validity of the MSF tool has been tested, confirming that MSF provides a reliable method of performance assessment and a feasible method of assessing clinician performance in terms of response rates, time and costs.[21] More recently, a critical review of MSF and its psychometrics noted that publications over the past 50 years or more in the business and health literature support MSF for quality improvement purposes.[22]

Specific research validating the use of the MSF in the clinical setting covers, for example:

Topic	Research
Validity/reliability	Psychometric feasibility and acceptability studies of the instruments in 9 specialty areas and 2 provinces demonstrated high reliability and validity.[13,16,23-33] The consistency of feedback scores between assessor groups was moderate to high and structural validity for the MSF tool was high. Both technical and non-technical competencies have been assessed by the MSF tool encompassing: • professionalism • communication • management • interpersonal skills and relationships • collegiality (collaboration) • leadership • decision-making • system-based practice • probity • knowledge • judgement. Note: The MSF tool is designed to assess interpersonal skills and observable behaviours. MSF is not designed to assess areas that patients, colleagues and co-workers don't observe on a regular and reliable basis including the clinician's role as medical expert, scholar and health advocate.

Topic	Research
Feasibility	Feasibility of implementation of the MSF tool is high as assessments take a short time to complete, are cost-effective and achieve high response rates.[23-26,34]
Scoring	Systematic reviews,[16,24,26] meta reviews,[35] scoping reviews[36] and critical reviews[22] have been undertaken to determine the evidence for using MSF scores in both medical practice and medical education settings.
Comparison	Comparison studies with other MSF instruments are favourable.[37] In addition, comparison with other workplace-based assessment demonstrates that MSF provides a valid representation of clinician performance.[24,25,27]
Consequences and change	Examinations of clinicians' use of the feedback to make changes following MSF are overall positive, with mixed results about the likelihood of change following negative feedback or where feedback is inconsistent with a clinician's own perceptions of their performance. This prompted the recommendation that facilitated feedback be provided. Repetitive feedback and the ability to reflect on the results, together with facilitated feedback, increase the likelihood of change.[25-28,38-42]
Barriers and enablers	Explorations of the barriers and enablers to using the data to make changes in practice.[43-45]
Facilitated feedback	Examinations of the utility of having a facilitated reflective feedback discussion to discuss the data and the report, the clinician's reflections on them, the strengths and opportunities identified by them and plans to use the data for improvement.[21,44,46]
Data	Assessments of longitudinal changes in data for clinicians who participated in Physician Achievement Review on more than one occasion.[29,32]
Performance	Relationship with the Medical Board of Australia's Professional Performance Framework[47] and comparisons of clinician performance by the Canadian school of graduation.[8,29]
Quality	Measuring the quality of hospital doctors through colleague and patient feedback.[48,49]
Academic appointments	An examination of the association between the original PAR ratings and academic appointments and teaching.[50]

Table 3: MSF research summary. *Source: Developed by CFEP Surveys, 2022.*

The work has also led to systematic reviews of MSF. For example, exploring the role Self-Assessment plays when interpreting performance feedback has led to the development of a robust model for facilitated coaching feedback about performance data (i.e. the R2C2 model, discussed on page 61).[21,39,46]

CFEP Surveys actively shares research findings and provides opportunities for linkage and research exchange, including via:

- CFEP Surveys website (**www.cfepsurveys.com.au**)
- MSF mailing list (to connect and receive regular updates email: **info@cfepsurveys.com.au**)
- regular and ongoing conversations with key stakeholders
- an annual national MSF virtual seminar, which includes international guests and industry leaders.

MSF has enabling and limiting factors

Research into the implementation of MSF has identified key enablers and success factors (Table 4).[10,38,43,51,52]

Enabler	Success factors
Focus on observable behaviours	All MSF instruments and specific items were assessed for observability during the development of each instrument through focus group testing and are considered observable. Subsequent research has corroborated this.
Focus on core professional roles i.e. collaborator, communicator, professional	The roles of communicator, collaborator and professional are core to everyday clinical practice and influence patient outcomes and safety. They are easy to observe and score and provide useful insight into professionalism and practice, and identify opportunities for professional development, growth and improvement.
Use of a Likert scale with neutral midpoint and 'unable to assess' options	MSF instruments use a five-point Likert scale (i.e. poor to excellent) with a neutral midpoint and the option for reviewers to select 'unable to assess'. This simple approach is found to be viable: more than five points leads to confusion over meaning and distinctness of options. Further, the goal in MSF is not to rank clinicians but to provide feedback about strengths and opportunities for improvement. A neutral midpoint is used to avoid non-response bias.[53]
Numbers of respondents, feasibility and reliability	Several studies have examined the reliability or dependability of the data provided to clinicians. Generalisability studies (G-studies) have shown it is difficult to get reliability at the levels normally considered acceptable for high-stake decision-making (e.g. summative assessment). Studies have demonstrated that 12 colleague responses (i.e. clinical colleagues and non-clinical co-workers) and [54] patient responses are required to provide a reasonable level of dependability for formative assessment purposes.[48] Note: Patient heterogeneity accounts for the need for more patient than colleague reviewers.

Enabler	Success factors
Invite free-text comments	MSF instruments encourage clinical colleague and non-clinical co-workers and patients to add comments focused on specific areas of practice the candidate does well in, as well as areas the candidate can target for improvement. It is known that the way the questions are posed when garnering such comments will affect the nature and type of comments received. Typically, candidates can expect around 25 per cent of reviewers will provide free-text comments which will generally be positive. Non-clinical colleagues typically provide more comments than clinical colleagues, and comments may span all three roles (collaborator, communicator, professional) with variable degrees of specificity, actionability and polarity.[51,52] Current wording reflects work that examined two models of questioning and identified questions with the greatest numbers of responses. All MSF instruments are reviewed regularly for utility and wording is modified as required.[37,52,55]
Self-selection of reviewers	Having clinicians select their own respondents is the most controversial aspect of the MSF process.[12,56] Initial studies suggested the data was similar whether the clinician selected respondents or others selected the respondents. More recent work suggests clinicians who are not performing well receive higher ratings from clinical colleagues they select than those who are selected for them. Other studies suggest bias created by how well the clinician knows the reviewer (clinical or non-clinical). While it may be feasible for a third party to identify reviewers, it may be impractical depending on the setting and context. CFEP Surveys recommends that candidates review guidance on selecting reviewers and the survey instruments, and identify clinical colleagues, non-clinical co-workers and patients who can observe their behaviours and provide ratings objectively.
Reporting data and providing feedback	CFEP Surveys recognises that feedback reports need to be clear, succinct and precise. A challenge noted in several studies relates to clarity of data and its utility when using the data to guide change activity. When clinicians receive ratings from clinical colleagues and non-clinical co-workers that are lower than anticipated, there may be an emotional reaction to the data which may hinder reflection and action planning (one rationale for effective facilitation/coaching).[44,57] The CFEP MSF report has been field tested and will continue to be assessed for comprehension and utility. The report provides guidance to candidates on interpreting the results, and includes questions to guide critical reflection, self-perception of how they are performing, performance strengths and opportunities for improvement.

Enabler	Success factors
Understanding the importance of Self-Assessment	Research in medical education over the past 10–15 years[57-60] has confirmed what earlier cognitive psychologists had identified for the general population,[60] which is that Self-Assessment undertaken as an individual appraisal, uninformed by external data, is generally flawed. During the early development of the original 360-degree assessment tool, it was found that candidate willingness to accept aggregated 360-degree assessment data was directly correlated with their scores (i.e. those with higher scores were more willing to accept them while those with lower scores were less inclined to do so).[28,46] Subsequent research identified that: • Interpretation of data and the decision to accept and use them is a complicated and sensitive process. • Self-Assessment benefited from data from multiple external sources (e.g. colleagues, co-workers, supervisors, patients) and explorations of internal and emotional reactions to the data.[39,59,61,62] Results of this research led to the notion of 'informed Self-Assessment', built on work demonstrating the need for Self-Assessment to be externally informed or guided.[58,63] Results also led to the question: *If external data are needed to inform one's Self-Assessment, and yet individuals are reluctant to take on that external data, especially if the data disconfirm their own perceptions, how might we facilitate acceptance and use of those data for performance improvement?* This led to a subsequent body of research addressing feedback.
Using a facilitated feedback conversation and coaching techniques to guide self-reflection and action planning	Clinicians and researchers have identified the need for MSF candidates to have facilitated, reflective feedback discussions about their feedback and data. Factors found to influence the acceptance and use of MSF were the format of the feedback, specifically whether it was facilitated or whether narrative comments were included in the review, and whether the feedback was from sources the clinician believed to be knowledgeable and credible.[4–7,38] Guided reflection encourages the candidate to consider and critically appraise their performance: to examine their own perceptions of how they are doing, their understanding of their scores and implications, and differences in their self-ratings and those of others. Facilitated reflection enables self-direction by encouraging candidates to identify strengths, consider goals, and plan for professional development, growth and improvement. Industry research has identified the important role the facilitator or coach[64-67] plays in promoting reflection and effecting performance change following 360-degree assessment. Medical education research to enhance clinicians' acceptance and use of their MSF and other performance data led to the development of the R2C2 facilitated, reflective feedback model. Within the MSF process, varied approaches to supported self-reflection may be undertaken (i.e. informal and formal debrief). Regardless of the option chosen, facilitated conversation should focus on the data in each report as well as triangulated data across reports. Common themes need to be explored with the candidate to develop an action plan. To ensure these discussions are formative, they should focus relative strengths and opportunities for improvement such that the process of generating an action plan is normalised within a supportive professional, peak body and provider learning culture.

Enabler	Success factors
Creating an action plan for professional development, growth and improvement	Learning contracts are now considered standard practice in clinical education, particularly continuing clinical education.[68-74] New Medical Board of Australia CPD requirements require clinicians to establish an annual plan (i.e., an explicit commitment to change), measure and reflect on outcomes.[54,75] MSF lets clinicians use objective data to identify and act on a range of opportunities for change across core roles including communicator, collaborator, and professional. Knowledge translation research has identified many barriers to making changes in clinical practice (e.g. beliefs about one's ability to change, practice context, colleagues and support). Exploring these factors during facilitated reflection and developing an action that incorporates these factors has proven helpful to MSF candidates.
MSF is a formative/ quality improvement vs. summative assessment tool	MSF is considered most effective as a formative or quality improvement tool.[22,76] G-study assessments are consistent in their findings (i.e., reliability isn't sufficiently high for summative assessment and high-stake decision-making). MSF focuses on a small but important component of a clinician's practice, and performance assessment scores may be skewed to the positive end of the spectrum, thereby creating a narrow range of results. As such, both educators and researchers recommend that MSF be used as a formative assessment tool which may trigger/be combined with other assessments to determine a fuller perspective of a clinician's performance.

Table 4: MSF enablers and success factors.
Source: Developed by CFEP Surveys, 2022.

All assessment tools, including the MSF tool, have both limitations and parameters that inform best practice. Table 5 outlines identified limitations of MSF.

Theme	Limitation
Culture	MSF best operates within a professional and peak body, college, registered training organisation or provider organisation which adopts a whole-system learning approach to enhance patient safety and quality, which promotes professional development, growth and improvement, rather than adopts a punitive approach.[77-80]
Formative assessment	While MSF has been used in summative ways, psychometric analyses (particularly reliability analyses) suggest that MSF within clinical contexts is best used in a formative way and in conjunction with other assessments.[76,81-83]
Number of respondents	MSF requires a sufficient number of respondents to provide reliable or dependable assessments since data are aggregated and anonymity must be preserved.[36,84]
Realising change	Organisational resources are required post-MSF to create the supportive environment in which the clinicians can implement their personal development, growth and improvement action plan.[16]
Resource requirements	A stable human resources infrastructure is required to manage the processes of MSF program implementation and communication, and to ensure mechanisms are in place for reporting and feedback. People are limited in their ability to interpret data and use the data to develop robust action plans unaided. Coaching and other support systems are recommended to optimise the use of the data. Clinicians have variable ability to draw on and use data effectively.[36,84]
Stimuli are daily, real events that are random and different for every observer	A lack of standardisation may create challenges in data interpretation. Similarly, historical information about a clinician may have an impact on assessments. This limitation is, in fact, one of the reasons that aggregation of observations, such as that enabled by the MSF tool, is so valuable.[36,84]

Table 5: MSF limitations.
Source: Developed by CFEP Surveys, 2022.

The CFEP Surveys MSF tool is a market-leading program

MSF refers to the complete clinician performance and practice assessment based on all three instruments and feedback sources:

Interpersonal Skills Questionnaire (ISQ) – *What is my patient's experience of care?*

Patient contributions to assessing a health professional's practice are generally underutilised. The MSF tool's Interpersonal Skills Questionnaire is considered a patient reported experience measure (PREM) and measures the patient experience of a clinician's care. It offers a feasible way to collect unique data from patients to provide a balanced picture of a clinician's interpersonal skills in their roles as communicator and collaborator.

The Interpersonal Skills Questionnaire allows patients to give feedback on the humanistic aspects of care. It is behaviourally based so clinicians can focus on strengthening their interpersonal skills in light of patient feedback. It addresses behaviours such as warmth of greeting, listening skills, clarity of explanations, respect for the patient, and involving patients in decision-making, and gives an indication of the patient's confidence in the clinician's ability.

CFEP Surveys developed this validated instrument following extensive engagement with consumers about what they expect when visiting a clinician. Initially developed to assess a clinician's interpersonal skills, the original Doctors' Interpersonal Skills Questionnaire (DISQ)[15] was refined.

The Interpersonal Skills Questionnaire and takes a patient roughly three minutes to complete, online via a unique URL or QR code. Thirty completed responses are required to ensure validity of data.

Interpersonal Skills Questionnaire

0 1 5 8 A

OFFICE USE ONLY

Org ID

Survey ID

Practitioner ID

DR EXAMPLE

You can help improve the quality of care for patients

- The would welcome your honest feedback
- The will not be able to identify your personal responses
- Any comments you make will be included in the feedback report but all attempts will be made to remove information that could identify you.

Please mark the box like this ☒ with a ball point pen. If you change your mind just cross out your old response and make your new choice. If you are unable to answer a question, or a question doesn't apply to you, please leave it blank.

When giving your feedback, please only consider the consultation you have had today.

	Please rate the following based on your visit today	Poor	Fair	Good	Very good	Excellent
1	My overall satisfaction with this visit to the doctor is	☐	☐	☐	☐	☐
2	The warmth of the doctor's greeting to me was	☐	☐	☐	☐	☐
3	On this visit I would rate the doctor 's ability to really listen to me as	☐	☐	☐	☐	☐
4	The doctor 's explanations of things to me were	☐	☐	☐	☐	☐
5	The extent to which I felt reassured by this doctor was	☐	☐	☐	☐	☐
6	My confidence in this doctor 's ability is	☐	☐	☐	☐	☐
7	The opportunity the doctor gave me to express my concerns or fears was	☐	☐	☐	☐	☐
8	The respect shown to me by this doctor was	☐	☐	☐	☐	☐
9	The amount of time given to me for this visit was	☐	☐	☐	☐	☐
10	This doctor 's consideration of my personal situation in deciding a treatment or advising me was	☐	☐	☐	☐	☐
11	The doctor 's concern for me as a person on this visit was	☐	☐	☐	☐	☐
12	The extent to which the doctor helped me to take care of myself was	☐	☐	☐	☐	☐
13	The recommendation I would give to my friends about this doctor would be	☐	☐	☐	☐	☐

The doctor would appreciate any suggestions as to how he/she could improve:

The following questions provide us only with general information about the range of people who have responded to this survey. This information will not be used to identify you and will remain confidential.

How old are you in years? ☐ Under 25 ☐ 25-59 ☐ Over 60

Are you: ☐ Female ☐ Male

Was this visit with your usual doctor? ☐ Yes ☐ No

Thank you for your time and assistance in completing this questionnaire

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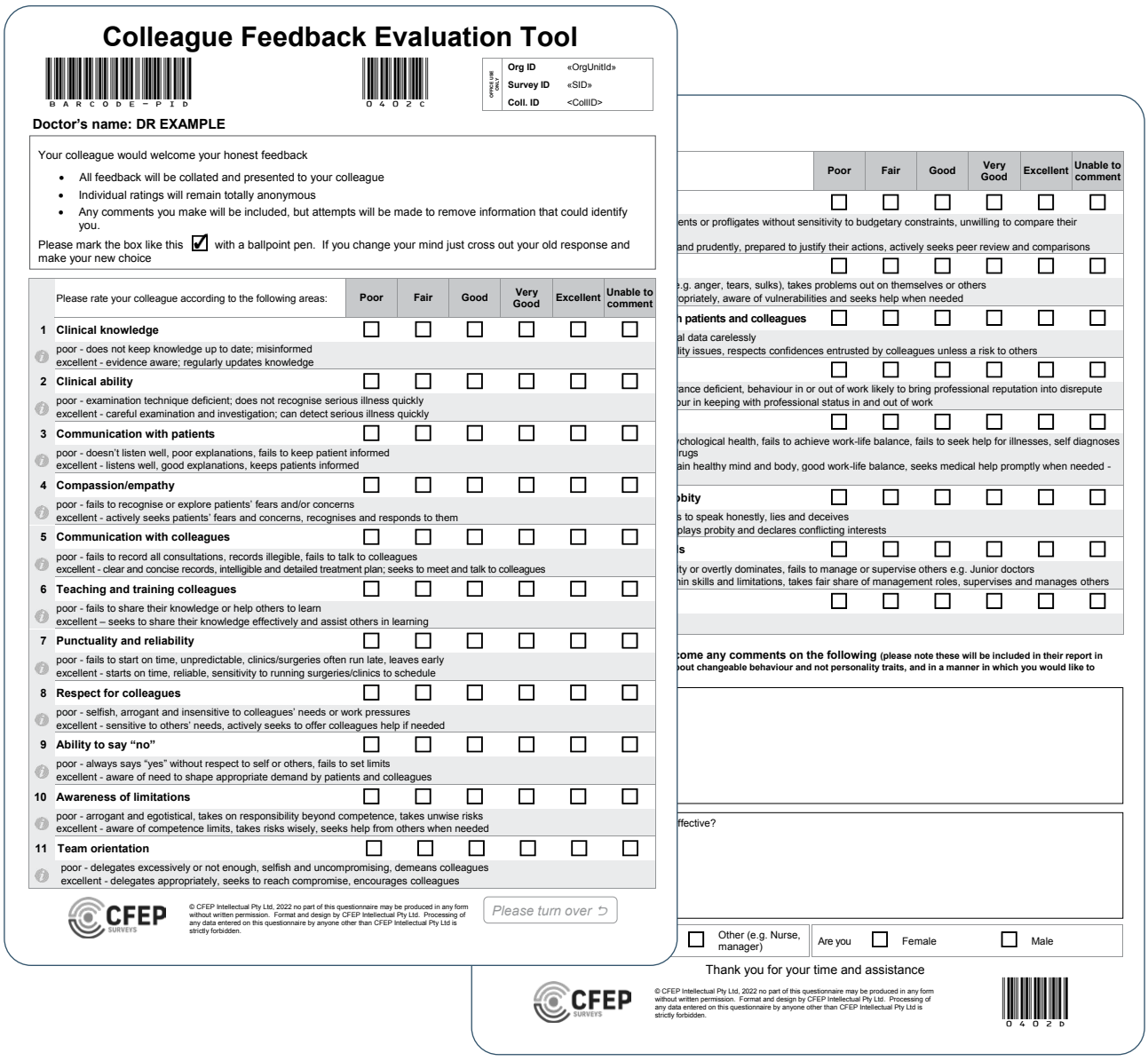
Figure 8: The MSF tool Interpersonal Skills Questionnaire (ISQ).
© CFEP Surveys

Colleague Feedback Evaluation Tool (CFET) – *How am I perceived by my colleagues?*

Feedback obtained from a wide spectrum of peers, clinical colleagues and non-clinical co-workers is considered a reliable assessment of a clinician's professionalism. The CFET is a validated survey instrument designed to give clinicians feedback on many aspects of their practice and performance, including clinical ability, reliability, communication with patients and colleagues, teamwork, personal grooming, stress management, and attention to personal and professional development. This feedback complements and is conducted alongside the clinician's Self-Assessment.

The online questionnaire, is administered via CFEP Surveys secure portal, and requires feedback from a minimum of 12 colleague reviewers (i.e. a balanced mix of clinical colleagues and non-clinical co-workers) to ensure data validity.



Colleague Feedback Evaluation Tool

BARCODE-PID

0402C

OFFICE USE ONLY

Org ID «OrgUnitId»
Survey ID «SID»
Coll. ID <CollID>

Doctor's name: DR EXAMPLE

Your colleague would welcome your honest feedback

- All feedback will be collated and presented to your colleague
- Individual ratings will remain totally anonymous
- Any comments you make will be included, but attempts will be made to remove information that could identify you.

Please mark the box like this ☑ with a ballpoint pen. If you change your mind just cross out your old response and make your new choice

	Please rate your colleague according to the following areas:	Poor	Fair	Good	Very Good	Excellent	Unable to comment
1	**Clinical knowledge**	☐	☐	☐	☐	☐	☐
	poor - does not keep knowledge up to date; misinformed excellent - evidence aware; regularly updates knowledge						
2	**Clinical ability**	☐	☐	☐	☐	☐	☐
	poor - examination technique deficient; does not recognise serious illness quickly excellent - careful examination and investigation; can detect serious illness quickly						
3	**Communication with patients**	☐	☐	☐	☐	☐	☐
	poor - doesn't listen well, poor explanations, fails to keep patient informed excellent - listens well, good explanations, keeps patients informed						
4	**Compassion/empathy**	☐	☐	☐	☐	☐	☐
	poor - fails to recognise or explore patients' fears and/or concerns excellent - actively seeks patients' fears and concerns, recognises and responds to them						
5	**Communication with colleagues**	☐	☐	☐	☐	☐	☐
	poor - fails to record all consultations, records illegible, fails to talk to colleagues excellent - clear and concise records, intelligible and detailed treatment plan; seeks to meet and talk to colleagues						
6	**Teaching and training colleagues**	☐	☐	☐	☐	☐	☐
	poor - fails to share their knowledge or help others to learn excellent – seeks to share their knowledge effectively and assist others in learning						
7	**Punctuality and reliability**	☐	☐	☐	☐	☐	☐
	poor - fails to start on time, unpredictable, clinics/surgeries often run late, leaves early excellent - starts on time, reliable, sensitivity to running surgeries/clinics to schedule						
8	**Respect for colleagues**	☐	☐	☐	☐	☐	☐
	poor - selfish, arrogant and insensitive to colleagues' needs or work pressures excellent - sensitive to others' needs, actively seeks to offer colleagues help if needed						
9	**Ability to say "no"**	☐	☐	☐	☐	☐	☐
	poor - always says "yes" without respect to self or others, fails to set limits excellent - aware of need to shape appropriate demand by patients and colleagues						
10	**Awareness of limitations**	☐	☐	☐	☐	☐	☐
	poor - arrogant and egotistical, takes on responsibility beyond competence, takes unwise risks excellent - aware of competence limits, takes risks wisely, seeks help from others when needed						
11	**Team orientation**	☐	☐	☐	☐	☐	☐
	poor - delegates excessively or not enough, selfish and uncompromising, demeans colleagues excellent - delegates appropriately, seeks to reach compromise, encourages colleagues						

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Please turn over ⮌

	Poor	Fair	Good	Very Good	Excellent	Unable to comment
	☐	☐	☐	☐	☐	☐
ents or profligates without sensitivity to budgetary constraints, unwilling to compare their and prudently, prepared to justify their actions, actively seeks peer review and comparisons						
	☐	☐	☐	☐	☐	☐
e.g. anger, tears, sulks), takes problems out on themselves or others opriately, aware of vulnerabilities and seeks help when needed						
h patients and colleagues	☐	☐	☐	☐	☐	☐
al data carelessly lity issues, respects confidences entrusted by colleagues unless a risk to others						
	☐	☐	☐	☐	☐	☐
ance deficient, behaviour in or out of work likely to bring professional reputation into disrepute our in keeping with professional status in and out of work						
	☐	☐	☐	☐	☐	☐
chological health, fails to achieve work-life balance, fails to seek help for illnesses, self diagnoses rugs ain healthy mind and body, good work-life balance, seeks medical help promptly when needed -						
obity	☐	☐	☐	☐	☐	☐
s to speak honestly, lies and deceives plays probity and declares conflicting interests						
s	☐	☐	☐	☐	☐	☐
ity or overtly dominates, fails to manage or supervise others e.g. Junior doctors hin skills and limitations, takes fair share of management roles, supervises and manages others						
	☐	☐	☐	☐	☐	☐

come any comments on the following (please note these will be included in their report in out changeable behaviour and not personality traits, and in a manner in which you would like to

ffective?

☐ Other (e.g. Nurse, manager) | Are you ☐ Female ☐ Male

Thank you for your time and assistance

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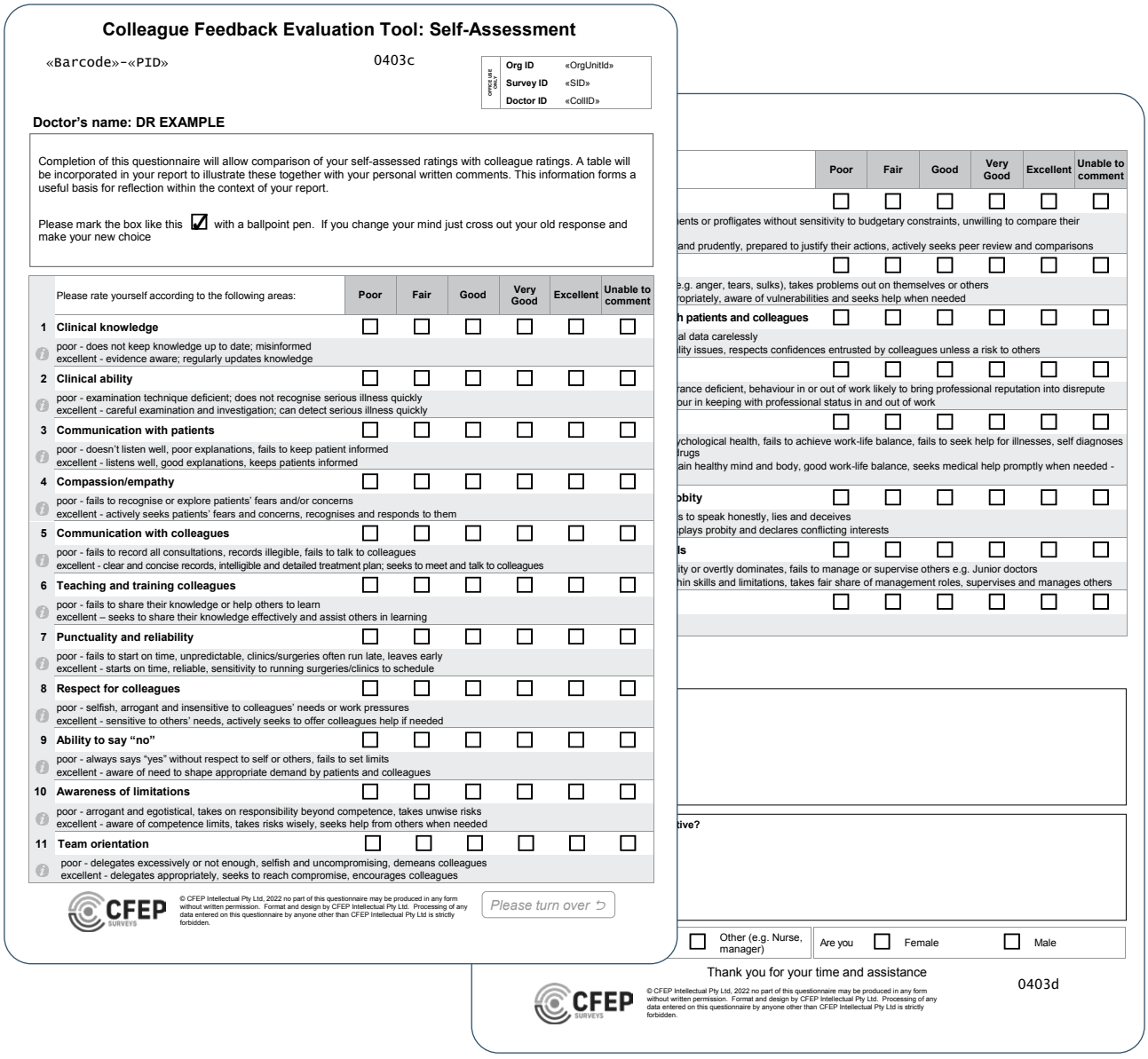
0402D

Figure 9: The MSF tool Colleague Feedback Evaluation Tool (CFET).
© CFEP Surveys

Self-Assessment (SA) – *Do I see myself as others see me?*

The SA is completed alongside colleague feedback, and mimics factors considered in that. It includes items identical to those included in the CFET. It allows a clinician to reflect on their own professionalism, and gives an insight into how the clinician views themselves and their own performance relative to others' perceptions. The SA instrument is administered via CFEP Surveys secure portal. To finalise the MSF tool, the clinician must return a completed SA.



Colleague Feedback Evaluation Tool: Self-Assessment

«Barcode»-«PID» 0403c

OFFICE USE ONLY: Org ID «OrgUnitId»; Survey ID «SID»; Doctor ID «CollID»

Doctor's name: DR EXAMPLE

Completion of this questionnaire will allow comparison of your self-assessed ratings with colleague ratings. A table will be incorporated in your report to illustrate these together with your personal written comments. This information forms a useful basis for reflection within the context of your report.

Please mark the box like this ☑ with a ballpoint pen. If you change your mind just cross out your old response and make your new choice

	Please rate yourself according to the following areas:	Poor	Fair	Good	Very Good	Excellent	Unable to comment
1	**Clinical knowledge**	☐	☐	☐	☐	☐	☐
	poor - does not keep knowledge up to date; misinformed excellent - evidence aware; regularly updates knowledge						
2	**Clinical ability**	☐	☐	☐	☐	☐	☐
	poor - examination technique deficient; does not recognise serious illness quickly excellent - careful examination and investigation; can detect serious illness quickly						
3	**Communication with patients**	☐	☐	☐	☐	☐	☐
	poor - doesn't listen well, poor explanations, fails to keep patient informed excellent - listens well, good explanations, keeps patients informed						
4	**Compassion/empathy**	☐	☐	☐	☐	☐	☐
	poor - fails to recognise or explore patients' fears and/or concerns excellent - actively seeks patients' fears and concerns, recognises and responds to them						
5	**Communication with colleagues**	☐	☐	☐	☐	☐	☐
	poor - fails to record all consultations, records illegible, fails to talk to colleagues excellent - clear and concise records, intelligible and detailed treatment plan; seeks to meet and talk to colleagues						
6	**Teaching and training colleagues**	☐	☐	☐	☐	☐	☐
	poor - fails to share their knowledge or help others to learn excellent – seeks to share their knowledge effectively and assist others in learning						
7	**Punctuality and reliability**	☐	☐	☐	☐	☐	☐
	poor - fails to start on time, unpredictable, clinics/surgeries often run late, leaves early excellent - starts on time, reliable, sensitivity to running surgeries/clinics to schedule						
8	**Respect for colleagues**	☐	☐	☐	☐	☐	☐
	poor - selfish, arrogant and insensitive to colleagues' needs or work pressures excellent - sensitive to others' needs, actively seeks to offer colleagues help if needed						
9	**Ability to say "no"**	☐	☐	☐	☐	☐	☐
	poor - always says "yes" without respect to self or others, fails to set limits excellent - aware of need to shape appropriate demand by patients and colleagues						
10	**Awareness of limitations**	☐	☐	☐	☐	☐	☐
	poor - arrogant and egotistical, takes on responsibility beyond competence, takes unwise risks excellent - aware of competence limits, takes risks wisely, seeks help from others when needed						
11	**Team orientation**	☐	☐	☐	☐	☐	☐
	poor - delegates excessively or not enough, selfish and uncompromising, demeans colleagues excellent - delegates appropriately, seeks to reach compromise, encourages colleagues						

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Please turn over ⮌

Other (e.g. Nurse, manager) Are you ☐ Female ☐ Male

Thank you for your time and assistance

0403d

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Figure 10: The MSF tool Self-Assessment (SA) instrument.
© CFEP Surveys

Each instrument uses a five-point Likert assessment scale (poor to excellent). There is also an 'unable to assess' option for those occasions when the reviewer does not have the necessary information to gauge a response. All instruments offer space for free-text comments about strengths and areas for improvement. Reviewers are encouraged to provide specific, useful comments in these areas. The individual candidate recruits reviewers.

The MSF tool can be implemented in part or full

While CFEP Surveys recommends using all three instruments in the MSF tool to comprehensively gauge a clinician's performance in their communicator, collaborator and professional roles, the MSF tool can be conducted in part.

Options for partial application include:

- Conduct patient feedback only, using the Interpersonal Skills Questionnaire survey instrument.
- Use only the Colleague Feedback Evaluation Tool and the Self-Assessment. These instruments are not available individually; they must be completed in combination so Self-Assessment results can be compared with peer, clinical colleague and non-clinical co-worker feedback.

CFEP Surveys offers bespoke variations of the MSF tool

Each instrument can be varied and tailored to a specific audience or setting, such as generalist, specialist, Aboriginal and Torres Strait Islander health worker, rural and remote health etc. For more information about specific audiences and bespoke instruments, see **cfepsurveys.com.au** or contact the CFEP Surveys team.

Some MSF instruments are tailored to the specific requirements of professional or peak body. For example, the Australian College of Rural and Remote Medicine (ACRRM) uses a bespoke version of the Doctors' Interpersonal Skills Questionnaire to garner patient feedback on their experience of doctors, and also a bespoke version of the CFET which includes a question about the rural and remote context.

A non-clinical MSF is available to support a whole-of-practice approach to MSF. It supports non-clinical staff, including practice managers and administration or operations teams.

MSF fits with continuous quality improvement

The annual cycle of MSF for clinicians is a four-stage process. These stages are founded on the philosophy and principles of continuous quality improvement (CQI) (Figure 11).

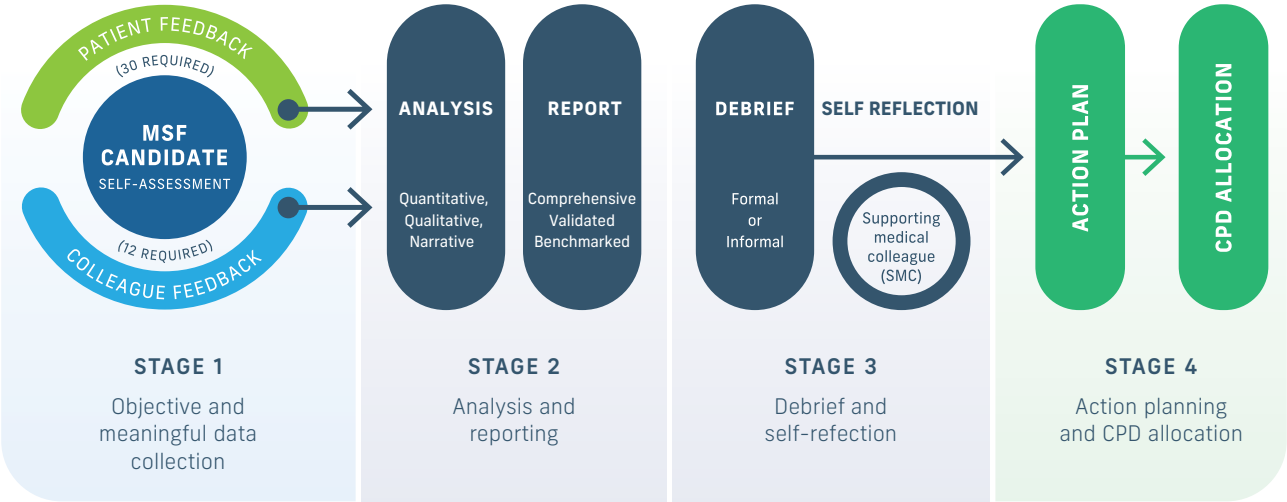


Figure 11: CFEP Surveys MSF process.
Source: Developed by CFEP Surveys, 2021.

At its simplest, CQI is a philosophy that encourages all health care providers to continuously ask:[86,87]

- How am I/we doing?
- Can I/we do better?
- What do I/we need to do to do better?
- How will I/we know I/we've improved?

CQI generates and reinforces a culture of excellence in which individual health care professionals and service providers continuously strive to be better tomorrow than what they were today. The key to creating a culture of excellence is using a structured review and planning approach that provides feedback on the current state, identifies the need for change activities to drive improvement and desired outcomes over time, and provides opportunity to meet that need.

Health care professionals can use the MSF tool to assess their performance (outcomes achieved) and develop a plan for personal development, growth and improvement (CPD and CQI).

The MSF process is based on the principles of CQI for health care professionals (Figure 12).

Figure 12: Process of CQI for health care professionals.[88-90]
Source: Adapted by CFEP Surveys, 2022.

While data from the MSF tool can identify for the clinician some improvement opportunities in their performance and practice, making the change is often more difficult. It can be especially challenging if the change is beyond the clinician's reach and requires a broader clinical or system change.
The MSF tool helps to capture and share these challenges to inform learning at the micro system level (the individual clinician and team level – the deliverers of care), the meso system level (service or organisation, training program etc.) or the macro system level (the health sector or local health system).[10]
When used optimally, the MSF tool underpins a whole-system learning approach to driving patient safety and quality improvement.

MSF complements other professional development and quality improvement approaches

MSF works towards the Quadruple Aim of health care[2] and value-based health care.[3] It helps drive continuous, data-driven quality improvement so clinicians can work at the top of their scope and help achieve high-performing health care nationally.

MSF is an important tool in the professional development and quality improvement 'toolkit'. A combination of data about interpersonal skills and professionalism (communicator, collaborator and professional roles), and data assessing the clinical expert role (application of clinical knowledge and skills and professional values) provides a more comprehensive and holistic view of an individual clinician's performance.

Common sources of performance data for the clinical expert role[91] include:

- clinical record audits
- prescribing patterns
- patient reported measures (PRMs)[92] including patient reported outcome measures (PROMs) such as the Patient Activation Measure® or PAM®[19,93] and patient reported experience measures (PREMs)[94]
- service-related process measures
- assessment of clinical procedures and standards.[95]

MSF is considered a formative assessment tool which provides assessment data to individual health care professionals and a more rounded picture of opportunities for learning, personal growth and improvement. It is not suitable for summative assessment purposes (i.e. to provide data to organisations for high-stakes decisions about a clinician's performance). Administered annually, the MSF tool gives an ongoing point-of-comparison where the MSF candidate's professional development can be measured year after year.

Optimally, results of the MSF tool would be considered alongside other performance data to guide professional development and CQI. Combining MSF results with other assessments of clinical expertise can give health care professionals a more extensive and authentic overview of their performance, a rich data source for identifying their practice strengths and areas where they could do better, and inform plans for improvement.

MSF aligns with the Medical Board of Australia's Professional Performance Framework

MSF is a formative workplace assessment tool[4,22] for informing personal development, growth and improvement, and so it complements the Medical Board of Australia's (MBA's) Professional Performance Framework.

The Professional Performance Framework supports doctors to practice competently and ethically throughout their career.[90] The framework creates a compact between patients and health care professionals that embraces clear expectations of professionalism, and safe and quality care. This compact safeguards the trust patients have in their doctors. The framework clearly aligns with the three roles assessed with the MSF tool (communicator, collaborator and professional), and with the MSF instruments, which assess interpersonal skills and the patient experience of care, colleague perceptions of professionalism in practice, and Self-Assessment.

Figure 13 gives an overview of the five pillars of the Professional Performance Framework.

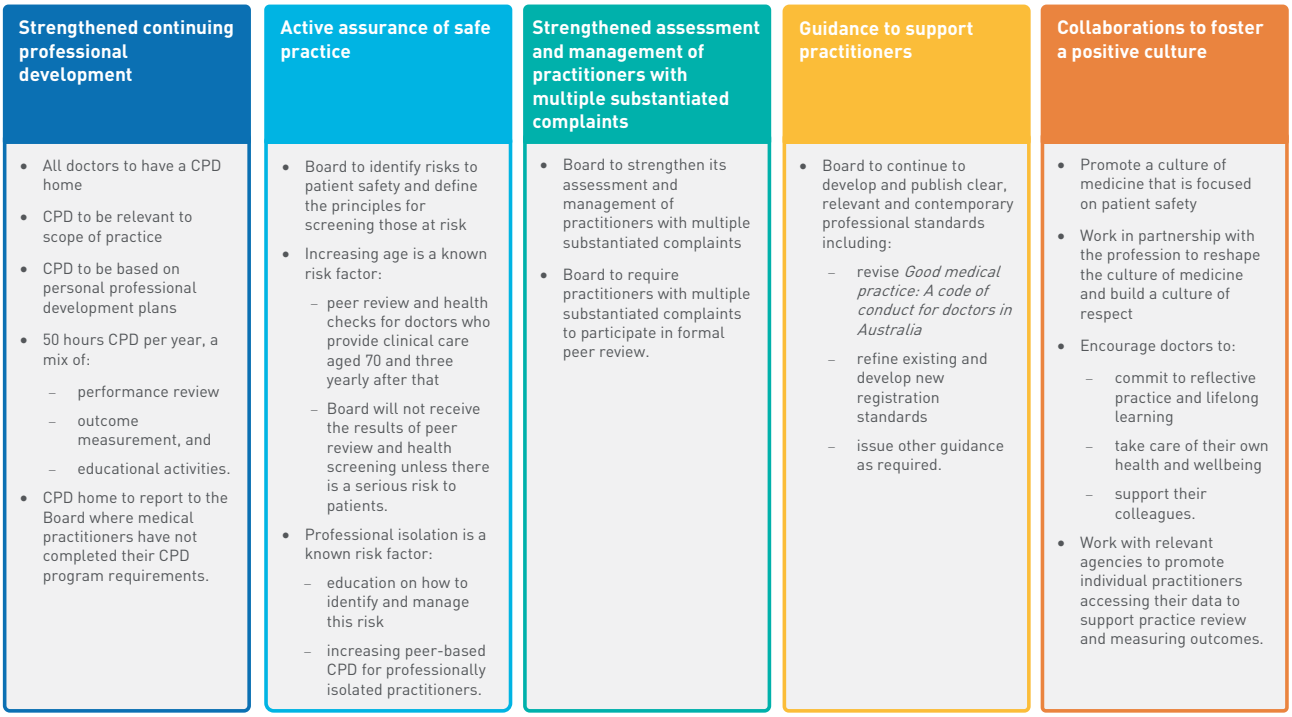


Figure 13: The five pillars of the MBA's Professional Performance Framework.[90]

The Professional Performance Framework is integrated into the MBA and colleges' pathways for medical registration (for both national and international medical graduates) and the ongoing professional development of health care professionals.

Complementary to the Professional Performance Framework is the introduction of a revised CPD registration standard[54,75] and health checks for late-career doctors, to support ongoing safe practice.

CPD requirements, effective from January 2023, are:[54,75]

- All doctors are required to nominate a CPD home (an organisation that validates the award of CPD hours in line with Professional Performance Framework requirements).
- CPD activities must comprise:
  - educational activities (at least 12.5 hrs)
  - performance review and outcomes measurement-related activities (at least 25 hours and a minimum of 5 hours each)
  - the remaining 12.5 hours across any of the above.

MSF meets two of the important components of the Professional Performance Framework and associated CPD requirements:

- **reviewing performance** (colleague feedback)
- **measuring outcomes** (patient feedback).

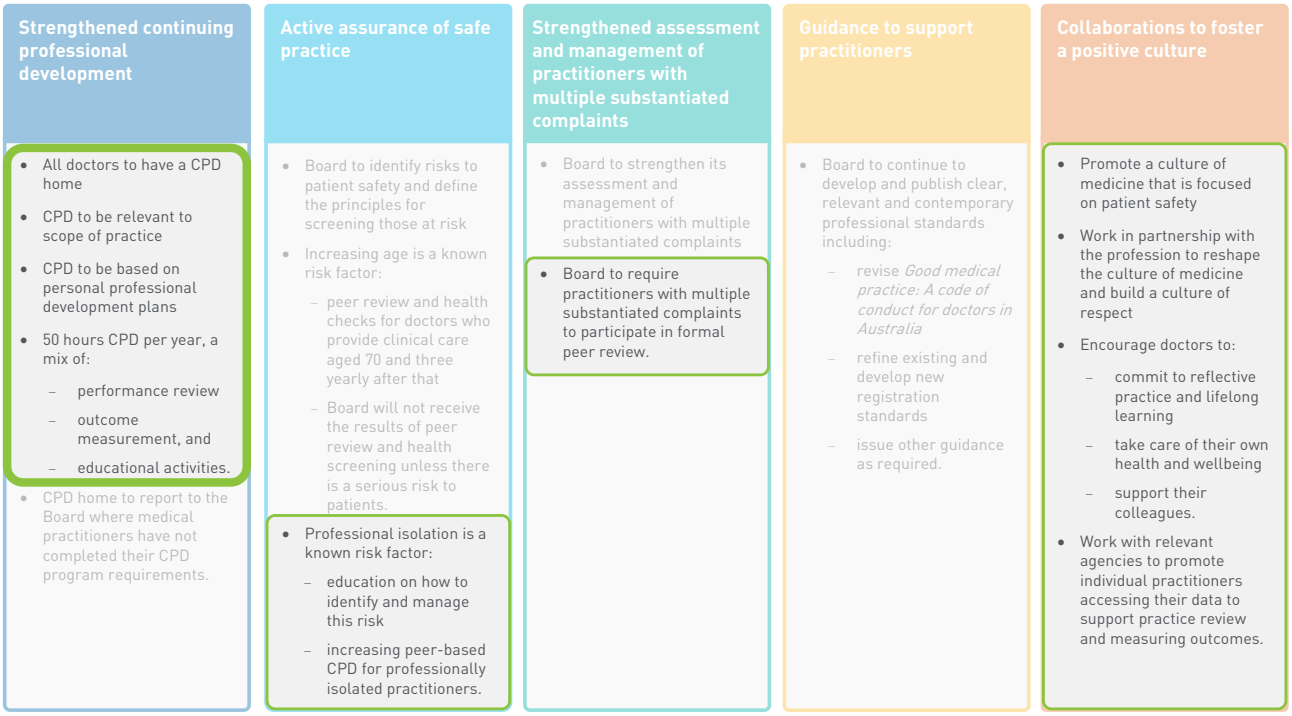


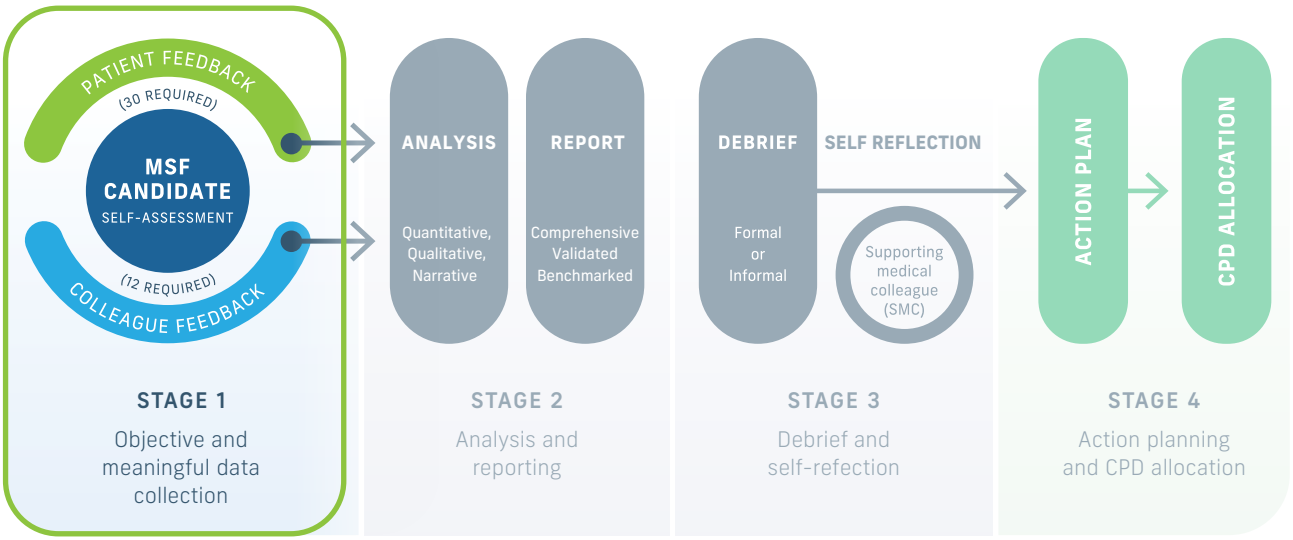
Figure 14: MSF alignment with the MBA's Professional Performance Framework.[54,75]
Source: Adapted by CFEP Surveys, 2022.

All medical colleges are recognised CPD homes, and independent CPD homes are established to support those clinicians not registered with a college. CPD homes don't necessarily develop or deliver education and professional development content, although many do. They promote opportunity for professional development, growth and improvement – for example, by adopting, promoting and enabling use of MSF to ensure an objective and evidence-based approach.

The MSF tool is a validated tool that not only reviews the clinician's performance and facilitates self-analysis and self-reflection but also measures outcomes and tracks these over time through annual review rounds. CPD recognition is awarded to MSF candidates on completion and submission of self-reflection records.

The MSF process is in four stages

Stage 1 – Objective and meaningful data collection



The candidate selects their colleague reviewers and advises CFEP Surveys. CFEP Surveys guides the MSF candidate, if required, when they're identifying their reviewers. While some raise concerns about the candidate selecting their own reviewers, the candidate is generally in the best position to identify people who know them and have observed or experienced their practice. Given the formative nature of the MSF tool, the data are more useful if candidates identify reviewers who can offer a variety of perspectives and accurately assess their performance.

CFEP Surveys invites the candidate to nominate a supporting medical colleague (SMC). CFEP Surveys recommends the candidate selects an SMC who is familiar with their work but not directly responsible for managing them or evaluating their performance. The SMC role is an informal but essential peer support throughout the MSF process.

A patient feedback pack (digital recommended) is issued, to be administered by the candidates practice or administration support team (to a sample of the candidates patients). The patient feedback process is administered by the candidates practice or administration support team. QR codes and short URLs will be sent via email, and if selected, a paper pack will be posted to the address the candidate provides.

CFEP Surveys guides the MSF candidate when they're identifying their reviewers. All identified reviewers must know the candidate and their clinical work well enough to give constructive and considerate feedback in a timely manner.

If digital collection is used, patient feedback data is more secure and more quickly processed and as such it is the recommended approach for all MSF candidates.

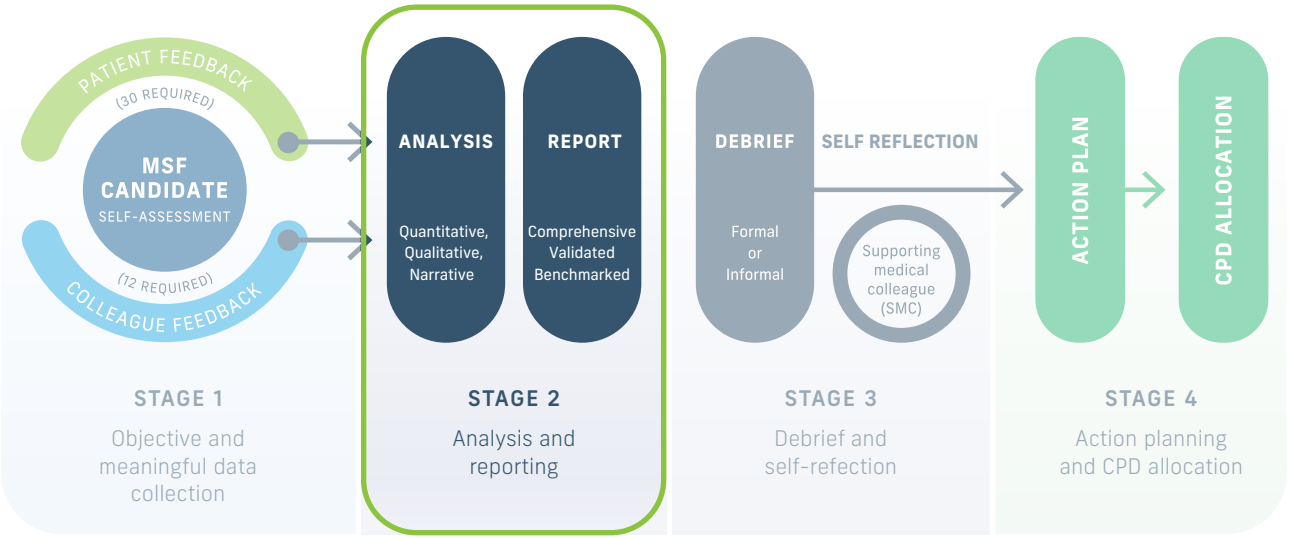
The candidate completes the Self-Assessment survey in the secure CFEP Surveys portal.

The reviewers complete either the Interpersonal Skills Questionnaire (patient) or the Colleague Feedback Evaluation Tool (colleague) which collects objective data about the MSF candidate's observable workplace interpersonal skills and professional behaviours.

Understanding the three instruments which make up Multi-Source Feedback

Instrument	Activities
Interpersonal Skills Questionnaire	• To ensure patient confidentiality, a nominated administrator will distribute the surveys to a minimum of 40 active patients and invite feedback. • The survey is easy to administer. It is available in online and paper formats. • The online version is accessible via a unique URL or QR code, and is directly submitted to CFEP Surveys via the secure portal. • The single-sided paper questionnaire is designed for the patient to complete and return via sealed envelope. • Both methods ensure patient anonymity and may be completed in about three minutes. • For report validity, a minimum of 30 completed, valid questionnaires are required. The responses are subsequently provided to and analysed by CFEP Surveys and inform the development of the patient feedback results report. • Note: Ethics approval is not required for the survey since data collection is quality improvement-focused rather than research-focused.[34]
Colleague Feedback Evaluation Tool	• The candidate provides CFEP Surveys with the names and email addresses of 15 nominated colleague reviewers (typically five doctors, five other clinical colleagues and five managerial or administrative staff). • CFEP Surveys invites each reviewer to complete the 10-minute online survey via CFEP's secure portal. • CFEP Surveys system automatically distributes reminders after one and two weeks, to secure a minimum of 12 responses for report validity.
Self-Assessment	• CFEP Surveys invited the MSF candidate to complete an individual 10-minute online Self-Assessment via CFEP Surveys secure portal.

Stage 2 – Analysis and reporting



CFEP Surveys receives a candidate's data (at the response rate required for data validity) and analyses it by source (i.e. patient, clinical colleague, and non-clinical co-workers).

Analysis and reporting retain anonymity. Free-text feedback is provided verbatim minus any personal identifiers.

Before completing MSF, it is worth confirming:

- Who will have access to the report?
- Who will see the results?
- Where the report will be stored?
- Who will have access to it in the future?

If the candidate is using the full MSF tool, **CFEP Surveys will give the candidate or participating provider organisation, supervisor or clinical educator a comprehensive MSF report,** with the feedback from all three instruments as well as comparator data where the items on surveys are identical.

For example:

For general practitioners

- All Practice Experience Program (PEP) reports are sent to the candidate's college only, who then upload them to the candidate's portal.
- For registrars, reports will typically be sent to the candidate and the college via separate emails.
- For fellows (ACRRM, RACGP), a report will be sent to the candidate only. (Note: A copy won't be supplied to the college.)

For specialists

- For registrars, reports will typically be sent to the candidate and the college via separate emails.
- For participating fellows, a report will be sent to them directly.
- For participating international medical graduates (IMGs), a report will be sent to the relevant college for distribution.

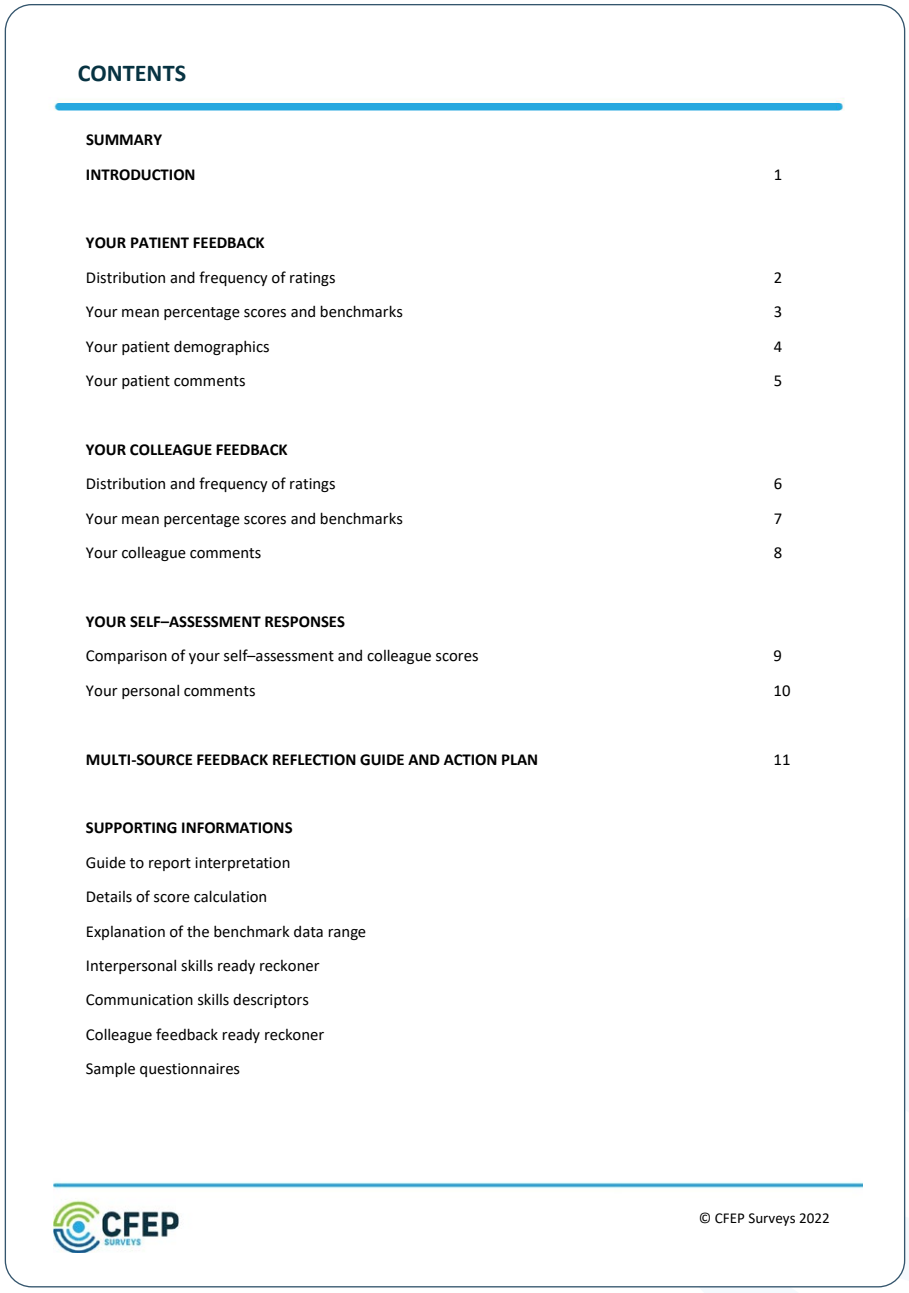
Where the candidate nominates a supporting medical colleague, it is the candidate who provides them a copy of the confidential MSF report.

CFEP Surveys comprehensive MSF report

The comprehensive MSF report gives a more rounded picture of the candidate's performance, encompassing feedback from all three sources.

When the candidate is completing individual components of the MSF assessment, CFEP Surveys will provide a copy (as appropriate) of the:

- **patient feedback report** – containing analysis of patient feedback, including benchmarking against your peers nationally, or
- **colleague feedback report** – containing the analysis of feedback from clinical colleagues and non-clinical co-workers, together with Self-Assessment comparators. Evaluation scores will be benchmarked against those of other participating clinicians.



CONTENTS

Figure 15: Example, MSF comprehensive Patient and Colleague Feedback report.
© CFEP Surveys

Each candidate will receive an introduction to the report. These outline how to read the report and interpret the data (providing sample copies of both the patient and colleague survey instruments, explaining data sources, analysis, and benchmarking), and orients the reader (MSF candidate or debriefer) to data-informed reflection.

Generally, reports contain, as appropriate:

- tabulated and graphical data and items showing how well the candidate scored in each item
- frequencies and average ratings for each item
- comparator data for self-ratings and the average colleague feedback rating
- free-text comments listed by question and source, minus any personal identifiers.

The graphical overview of results allows the candidate to decide whether they see themself as others see them.

It allows the candidate and debriefer to compare Self-Assessment scores with patient feedback on interpersonal skills and colleague perceptions of professionalism.

Benchmark data give a meaningful national average for candidates to consider where they sit along the continuum. They get a sense of how they are performing relative to other candidates who have completed MSF.

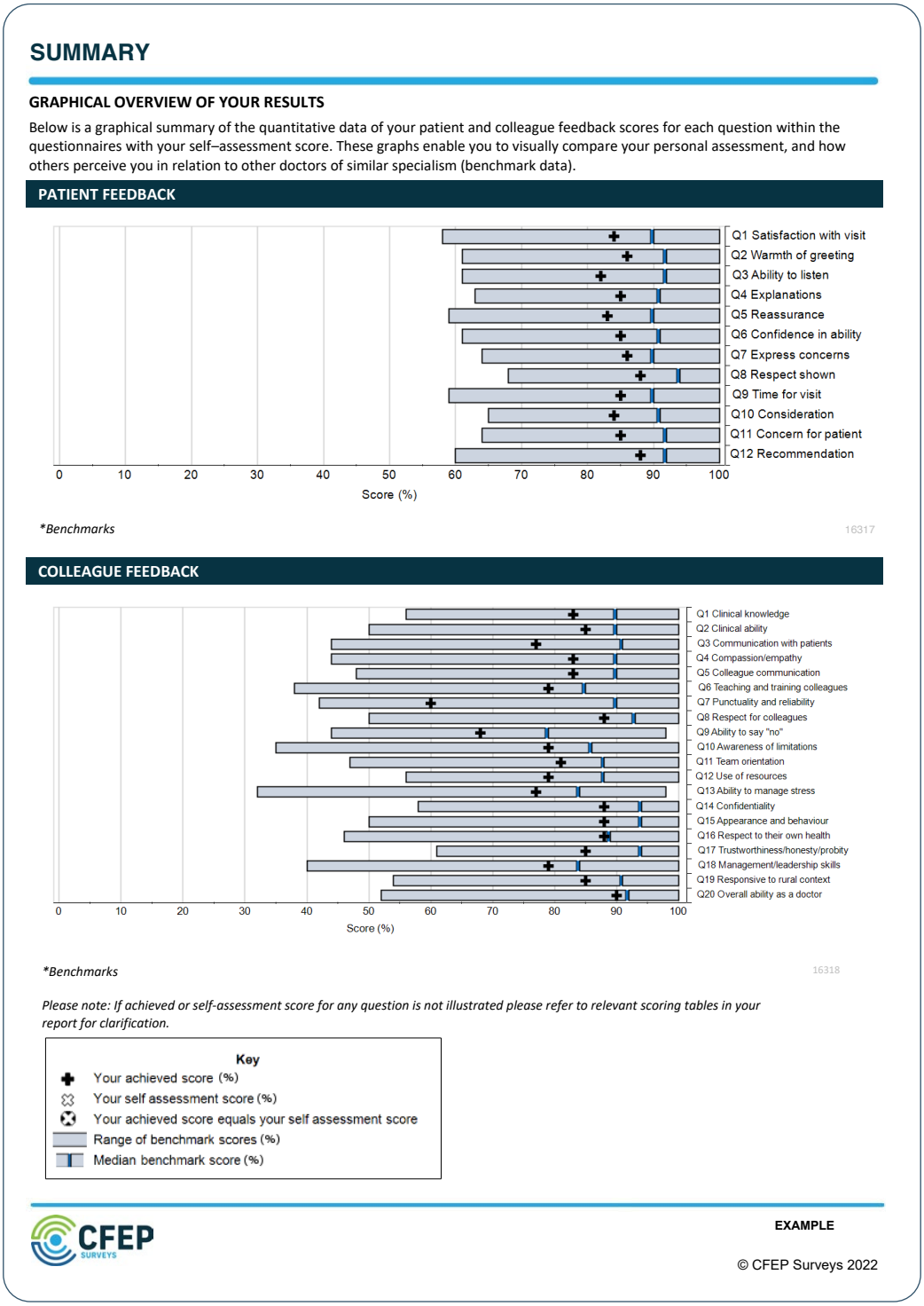


Figure 16: Graphical example of MSF results.
© CFEP Surveys

CFEP Surveys gives complementary guidance on how to:

- interpret and make the most of the report
- reflect on strengths and areas for professional and practice improvement (personal development, growth and improvement)
- next steps and how to use results to plan for change (action planning).

Patient feedback

The patient feedback report gives the results of the Interpersonal Skills Questionnaire. It addresses the question: ***What is my patient's experience of care?*** or put another way: *How do my patients rate my interpersonal skills and the experience of care I provide?*

The report outlines the distribution and frequency of ratings:

YOUR PATIENT FEEDBACK

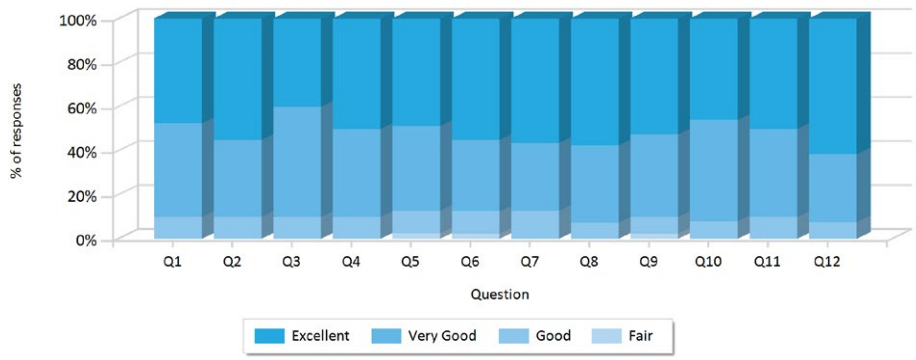
DISTRIBUTION AND FREQUENCY OF RATINGS

Table 1: Distribution and frequency of ratings from your patients

	Poor	Fair	Good	Very Good	Excellent	Blank / Spoilt
Q1 Satisfaction with visit	0	1	4	17	19	0
Q2 Warmth of greeting	0	0	4	14	22	0
Q3 Ability to listen	0	0	4	19	16	1
Q4 Explanations	0	0	4	16	20	0
Q5 Reassurance	0	1	4	15	19	1
Q6 Confidence in ability	0	0	4	13	22	0
Q7 Express concerns	0	0	5	11	23	1
Q8 Respect shown	0	0	3	14	23	0
Q9 Time for visit	0	1	3	15	21	0
Q10 Consideration	0	0	3	17	17	3
Q11 Concern for patient	0	0	4	16	20	0
Q12 Recommendation	0	0	3	12	24	1

Number of patients provided feedback: 40
Please note: Blank/spoilt responses are not included in your mean percentage score analysis.

Graph 1: Distribution and frequency of ratings from your patients



Please note: Blank/spoilt responses have not been incorporated in this graphical representation.

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© CFEP Surveys 2022

Figure 17: Example, Interpersonal Skills Questionnaire, distribution and frequency of rating.
© CFEP Surveys

It provides mean percentage scores and benchmarks:

YOUR PATIENT FEEDBACK

YOUR MEAN PERCENTAGE SCORES AND BENCHMARKS

Table 2: Your mean percentage scores and benchmarks

	Your mean score (%)	Benchmark data (%)*				
		Min	Lower Quartile	Median	Upper Quartile	Max
Q1 Satisfaction with visit	84	58	87	90	94	100
Q2 Warmth of greeting	86	61	88	92	95	100
Q3 Ability to listen	83	61	88	92	95	100
Q4 Explanations	85	63	87	91	94	100
Q5 Reassurance	83	59	86	90	93	100
Q6 Confidence in ability	85	61	87	91	94	100
Q7 Express concerns	86	64	87	90	94	100
Q8 Respect shown	88	68	90	94	96	100
Q9 Time for visit	85	59	87	90	93	100
Q10 Consideration	84	65	88	91	94	100
Q11 Concern for patient	85	64	88	92	94	100
Q12 Recommendation	88	60	88	92	95	100
Overall Score	85	64	88	91	94	100

16317

Your score falls in or above the highest 75% of all scores in the benchmark dataset

Your score falls in the 15% between the lowest 10% and the highest 75% of all scores in the benchmark dataset

Your score falls in or below the lowest 10% of all scores in the benchmark dataset

Number of patients provided feedback: 40
**Benchmarks*
Please note:

- *Where there are less than 5 responses for any question, the score will not be illustrated (--).*
- *Benchmark data is not available (-).*
- *Mean percentage score is the average of the responses for your responses. Please see supporting documents for more information on how the score is calculated and the quartile information.*
- *Benchmark Median: the numerical value that dissects the data in the middle (in half), where values above or below this value lies in the highest or lowest 50% of the mean percentage score values of all benchmarked data, respectfully.*

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EXAMPLE

Figure 18: Example, Interpersonal Skills Questionnaire, mean percentage scores and benchmarks.
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More comprehensive analysis outlines patient demographics and associated mean percentage scores:

YOUR PATIENT FEEDBACK

YOUR PATIENT DEMOGRAPHICS (BASED ON THOSE WHO COMPLETED THE QUESTIONNAIRE)

Table 3: Number of responses by demographic category

	Number of responses	Your mean score (%)	Benchmark data (%)* Min	Lower Quartile	Median	Upper Quartile	Max
Age							
Under 25	3	--	-	-	-	-	-
25 - 59	14	95	64	88	92	95	100
Over 60	13	90	63	87	91	94	100
Blank	0	--	-	-	-	-	-
Gender							
Female	19	92	60	88	92	95	100
Male	10	94	62	86	90	94	100
Blank	1	--	-	-	-	-	-
How many times have you seen this doctor							
Once only	21	90	56	85	90	93	100
More than once	8	99	57	89	93	96	100
Blank	1	--	-	-	-	-	-

16317

**Benchmarks*

Please note:

- *Where there are less than 5 responses for any question, the score will not be illustrated (--).*
- *Benchmark data is not available (-).*
- *Mean percentage score is the average of the responses for your responses. Please see supporting documents for more information on how the score is calculated and the quartile information.*
- *Benchmark Median: the numerical value that dissects the data in the middle (in half), where values above or below this value lies in the highest or lowest 50% of the mean percentage score values of all benchmarked data, respectfully.*

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EXAMPLE

Figure 19: Example, Interpersonal Skills Questionnaire, patient demographics and mean percentage scores.
© CFEP Surveys

Colleague feedback

The colleague feedback report provides the results of the Colleague Feedback Evaluation Tool, which assess the MSF candidate's professionalism. It addresses the question: ***How am I perceived by my colleagues?***

Again, this report details the distribution and frequency of rating, mean percentage scores and benchmarks, highlighting where the MSF candidate sits in relation to other scores within the relevant benchmark dataset.

YOUR COLLEAGUE FEEDBACK

YOUR MEAN PERCENTAGE SCORES AND BENCHMARKS

Table 5: Your mean percentage scores and benchmarks

	Your mean score (%)	Benchmark data (%)*				
		Min	Lower Quartile	Median	Upper Quartile	Max
Q1 Clinical knowledge	83	56	85	90	94	100
Q2 Clinical ability	85	50	84	90	94	100
Q3 Communication with patients	77	44	85	91	95	100
Q4 Compassion/empathy	83	44	85	90	95	100
Q5 Colleague communication	83	48	83	90	94	100
Q6 Teaching and training colleagues	79	38	79	85	90	100
Q7 Punctuality and reliability	60	42	84	90	95	100
Q8 Respect for colleagues	88	50	88	93	96	100
Q9 Ability to say "no"	68	44	73	79	83	98
Q10 Awareness of limitations	79	35	82	86	91	100
Q11 Team orientation	81	47	82	88	92	100
Q12 Use of resources	79	56	84	88	92	100
Q13 Ability to manage stress	77	32	78	84	89	98
Q14 Confidentiality	88	58	90	94	96	100
Q15 Appearance and behaviour	88	50	90	94	97	100
Q16 Respect to their own health	88	46	84	89	92	100
Q17 Trustworthiness/honesty/probity	85	61	91	94	97	100
Q18 Management/leadership skills	79	40	78	84	89	100
Q19 Responsive to rural context	85	54	86	91	95	100
Q20 Overall ability as a doctor	90	52	87	92	95	100
Overall Score	81	56	85	89	92	98

16318

	Your score falls in or above the highest 75% of all scores in the benchmark dataset
	Your score falls in the 15% between the lowest 10% and the highest 75% of all scores in the benchmark dataset
	Your score falls in or below the lowest 10% of all scores in the benchmark dataset

Number of colleagues provided feedback: 12
**Benchmarks*

Please note:

- *Where there are less than 5 responses for any question, the score will not be illustrated (--).*
- *Benchmark data is not available (-).*
- *Mean percentage score is the average of the responses for your responses. Please see supporting documents for more information on how the score is calculated and the quartile information.*
- *Benchmark Median: the numerical value that dissects the data in the middle (in half), where values above or below this value lies in the highest or lowest 50% of the mean percentage score values of all benchmarked data, respectfully.*

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EXAMPLE

Figure 20: Example, Colleague Feedback Evaluation Tool, mean percentage scores and benchmarks.
© CFEP Surveys

Similarly, it gives deidentified qualitative feedback, to complement patient feedback and Self-Assessment.

The doctor would appreciate any suggestions as to how they could improve.

✓ A valued member of the medical centre, very respected by her colleagues, patients and staff members.	✓ This doctor runs late at times, but always gives her patients 100% care and understanding. Undertakes nursing home and home visits when necessary.	✓ Has great empathy and consideration for people with mental health issues. She is aware of her limitations and utilises the mental health nurse in the practice for ongoing care of mental health patients and also for seeking information and support in the management of people with mental health issues.
✓ A very friendly and encouraging physician. She is well liked by both colleagues and patients. She uses her team and resources well and is confident when asking for additional advice or feedback where appropriate.	✓ This doctor is organised, respectful of her patients and other team members.	✓ This doctor could improve in timing, although this may be limited depending on the patient and reason for concern.
✓ Closure of wounds could be looser when tightening to assist with skin integrity and removal of sutures.		

Figure 21: Example, Colleague Feedback Evaluation Tool, colleague feedback – qualitative.
Source: Developed by CFEP Surveys, 2022.

In addition, patient comments are collated and qualitative data presented for consideration:

The doctor would appreciate any suggestions as to how they could improve.

✓ Waiting times.	✓ No improvement needed.	✓ Moving to a new area was made easy with this doctor, always there when needed and always happy to fit my kids in when they're sick.
✓ Very good doctor.	✓ There is nothing I could suggest. This doctor is an awesome doctor. She makes you feel very comfortable and is caring and concerned for me at every visit.	✓ I genuinely commit to my overall experience with this doctor. I consider her my forever doctor.
✓ Don't leave! I'm very happy.	✓ Time management.	✓ I feel this doctor is doing all the right things. She seems to care about what our problems are and will give advice on these matters or refer to a specialist or investigate by X-ray, etc.

Figure 22: Example, Interpersonal Skills Questionnaire, patient feedback – qualitative.
Source: Developed by CFEP Surveys, 2022.

Self-Assessment report

The candidate completes the Self-Assessment instrument alongside the Colleague Feedback Evaluation Tool and it is included in the report for comparison. The SA addresses the question: ***Do I see myself as others see me?*** It also captures personal reflections about strengths and opportunities for improvement.

YOUR SELF–ASSESSMENT RESPONSES

COMPARISON OF SELF–ASSESSMENT SCORES AND COLLEAGUE SCORES

Table 6: Comparison of self assessment and colleague scores

	Your assessment response	Your assessment equivalent percentage score*	Your colleague assessment mean percentage score*
Q1 Clinical knowledge	Very good	75	92
Q2 Clinical ability	Very good	75	93
Q3 Communication with patients	Excellent	100	95
Q4 Compassion/empathy	Excellent	100	96
Q5 Colleague communication	Excellent	100	87
Q6 Teaching and training colleagues	Excellent	100	92
Q7 Punctuality and reliability	Excellent	100	84
Q8 Respect for colleagues	Excellent	100	90
Q9 Ability to say "no"	Good	50	69
Q10 Awareness of limitations	Excellent	100	90
Q11 Team orientation	Excellent	100	90
Q12 Use of resources	Excellent	100	85
Q13 Ability to manage stress	Very good	75	90
Q14 Confidentiality	Excellent	100	95
Q15 Appearance and behaviour	Very good	75	84
Q16 Respect to their own health	Very good	75	92
Q17 Trustworthiness/honesty/probity	Excellent	100	95
Q18 Management/leadership skills	Excellent	100	88
Q19 Responsive to rural context	Excellent	100	98
Q20 Overall ability as a doctor	Very good	75	92

*See score explanation for percentage score calculation

Number of colleagues provided feedback: 15
**Please see supporting documents for more information on how the score is calculated.*

YOUR PERSONAL COMMENTS

From the free text component of the questionnaire. All comments have been included in their entirety

What are your other strengths?

- Friendly. Enjoys a diversity of work. Like to keep up to date and attend upskilling.

How could you become more effective?

- Time management, work-life balance.

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EXAMPLE

Figure 23: Example, Self-Assessment tool, comparison of Self-Assessment and colleague scores.
© CFEP Surveys

Performance reflection

In many MSF reports, a synthesis of results is presented in performance reflection tables. These highlight potential areas for personal development, growth and improvement, with more detailed information given in the body of the patient feedback or colleague feedback reports.

SUPPORTING INFORMATION

INTERPERSONAL SKILLS READY RECKONER

Once you have taken time to read and reflect on the patient feedback in your report, identify areas on which you can improve.

Each interpersonal skill item in the DISQ questionnaire has been mapped to communication skills. Review your mean score in the table below and work your way across the table to identify areas and skills you could focus you communication skills training to improve your performance.

Table 7: Communication skills mapped to the interpersonal skills items in the Patient Feedback Survey

			Communication Skills												
	DISQ Interpersonal Skill Items	Your % mean	Eye Contact	Agenda Setting	Common Language	Ask before tell	How does that fit with…?	Attributions and expectations	Empathy	What concerns you most	Interruptions	Touch and join	Names	Personal Information	Voice tone
C/F	Q2 Warmth of greeting	86	●										●		●
C/F	Q3 Ability to listen	83		●					●		●				
P	Q4 Explanations	85			●	●		●							
E	Q5 Reassurance	83							●	●				●	
P	Q6 Confidence in ability	85				●	●							●	
E	Q7 Express concerns	86				●				●		●			
C/F	Q8 Respect shown	88	●								●				●
C/F	Q9 Time for visit	85	●	●									●		
P	Q10 Consideration	84				●	●	●							
E	Q11 Concern for patient	85							●				●	●	

C/F=connect/friendliness
P=partnership
E=empathy

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EXAMPLE

Figure 24: Example, performance reflection – patient feedback.
© CFEP Surveys

CFEP Surveys provides supplementary information. It covers continuing professional development, details of score calculation, and explanation of the bench data range.

SUPPORTING INFORMATION

DETAILS OF SCORE CALCULATION

The score provided for each question in this questionnaire is the mean (average) value of all of the ratings from all patients/colleagues who completed the question. It is expressed as a percentage. This means the best possible score is 100%.

Non-rated responses (Unable to comment/blank/spoilt) are not used in the score calculations. (A blank response is where a patient/colleague did not respond to the question and a spoilt response is where more than one tick box option was chosen or the questionnaire was defaced).

Example from your Q2 Warmth of greeting — Total number of responses = 40

Questionnaire rating scale	Poor	Fair	Good	Very Good	Excellent	Non-rated responses
Value assigned to each rating	0	25	50	75	100	n/a
Number of responses	0	0	4	14	22	0

$$\frac{\text{(number of Poor ratings x 0) + (number of Fair ratings x 25) + (number of Good ratings x 50) + (number of Very Good ratings x 75) + (number of Excellent ratings x 100)}}{\text{(total number of patient responses - number of Non rated responses)}} = \frac{(0 \times 0) + (0 \times 25) + (4 \times 50) + (14 \times 75) + (22 \times 100)}{(40 - 0)} = \frac{3450}{40}$$

Your score for Q2 = 86%

EXPLANATION OF BENCHMARK DATA RANGE

	Your mean score (%)	Benchmark data (%)*				
		Min	Lower Quartile	Median	Upper Quartile	Max
Q2 Warmth of greeting	86	61	88	92	95	100

*Benchmarks are based on data from 712 surveys completed by ACRRM candidates between April 2017 and March 2022 with 28 or more returned questionnaires.

The benchmark data range provided divides the sampled population into quartiles. In statistics, a quartile refers to any of the three values that divides into four equal parts, where each part represents a quarter of the sampled population. Hence, the benchmark data quartiles comprise of:

- Lower quartile: below this value consists of the lowest 25% of the data
- Median: the numerical value that dissects the data in the middle (in half), where values above or below this value lies in the highest or lowest 50% of the mean percentage score values of all benchmarked data, respectfully.
- Upper quartile: above this value consist of the top 25% of the data.

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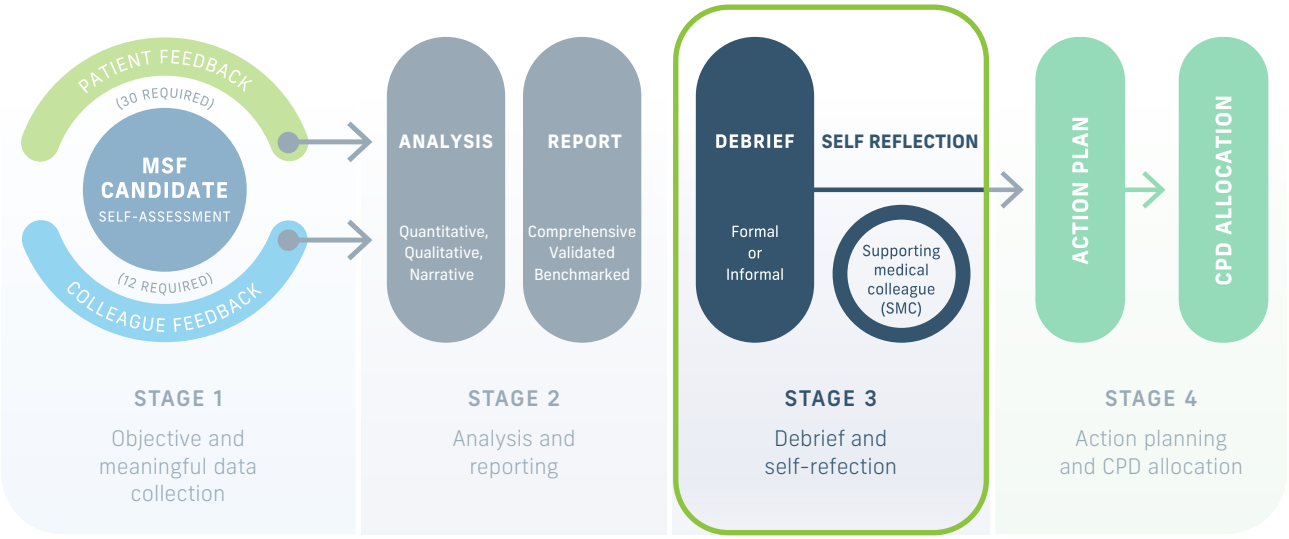
EXAMPLE

Figure 25: Example, Supplementary information: score calculations and benchmark data range.
© CFEP Surveys

Stage 3 – Debrief and self-reflection



Research in medical education demonstrates that simply receiving a report on one's performance is often **insufficient to promote learning or a change** in practice, even when gaps are readily apparent.[38,97]

While initial work in the development of MSF did not include facilitated debrief and self-reflection, the opportunity for candidates to discuss feedback is seen as critical to good outcomes from MSF.

As such, facilitated debrief and self-reflection, ideally performed by a trained coach, is the third stage of the MSF process and the precursor to developing a targeted improvement plan at stage 4.[11,15,34,43,96,97,100-102]

Figure 26 shows factors that influence **behaviour change to drive improvement.**[21,46,103,104]

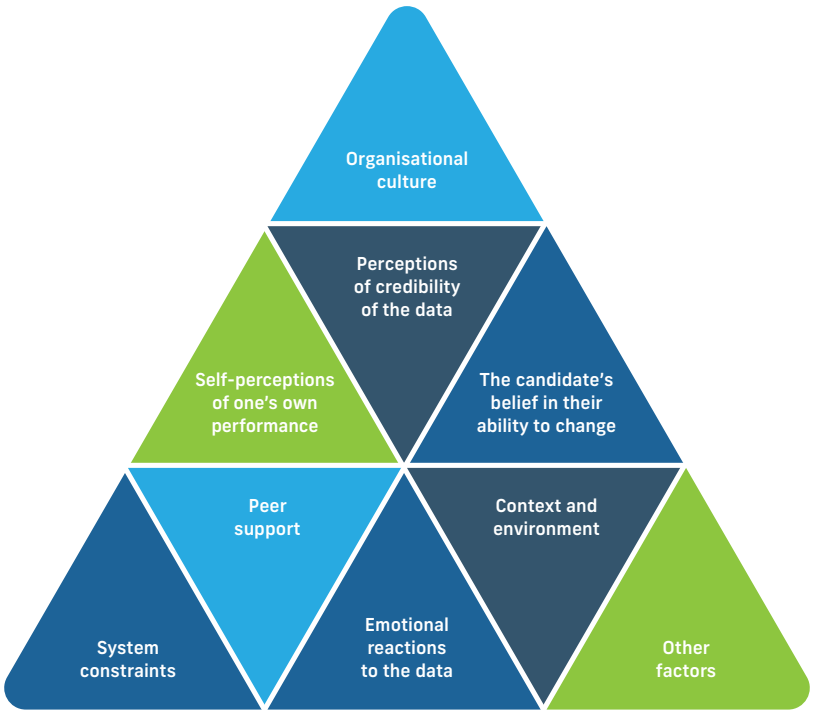


Figure 26: Factors that influence behavioural change.[21,46,103,104]
Source: Adapted by CFEP Surveys, 2022.

Making a personal, professional or practice change in response to performance data is complex and benefits from three specific interventions:

- having a facilitated feedback conversation about the MSF report and data
- adopting a coaching approach when considering the need for change
- co-developing an annual action plan for professional development, growth and improvement.

An important and compulsory component of the MSF process is the candidate's ability to meet with a trusted person to review the data and discuss the results. In recent implementation trials, 89 per cent of Royal Australian College of Physicians candidates agreed or strongly agreed that debrief was a valued component of the process.[105]

> ***'[The debrief] was without doubt the outstanding part of the process. The critical reflection I achieved in dialogue went vastly beyond the scope of what I could achieve looking at the report on my own and really crystallised some important but unrecognised professional issues for me.'***
>
> RACP MSF trial participant, 2017

Debrief and self-reflection goals include to:

- inform the co-development of an annual action plan for continuing professional development
- normalise the process of professional review and reflection as part of a supportive whole-system learning culture encompassing professional bodies and provider organisations
- (and, for clinicians who are excelling) focus on an aspirational change or improvement they may wish to make.

Reflective learning is an essential component of professional practice. It involves considering the results and thinking about the experiences of patients and colleagues retrospectively in order to learn from them. The debrief helps the candidate to 'unpack' their MSF report; where possible this should occur as soon as they receive the report.

But debrief and facilitated reflection can be challenging, even when results are positive. It requires leadership, adopting a coaching approach, and effective interpersonal skills based on trust and respect. Research has identified characteristics of the feedback conversation that enhance its effectiveness (Figure 27).[106-109]

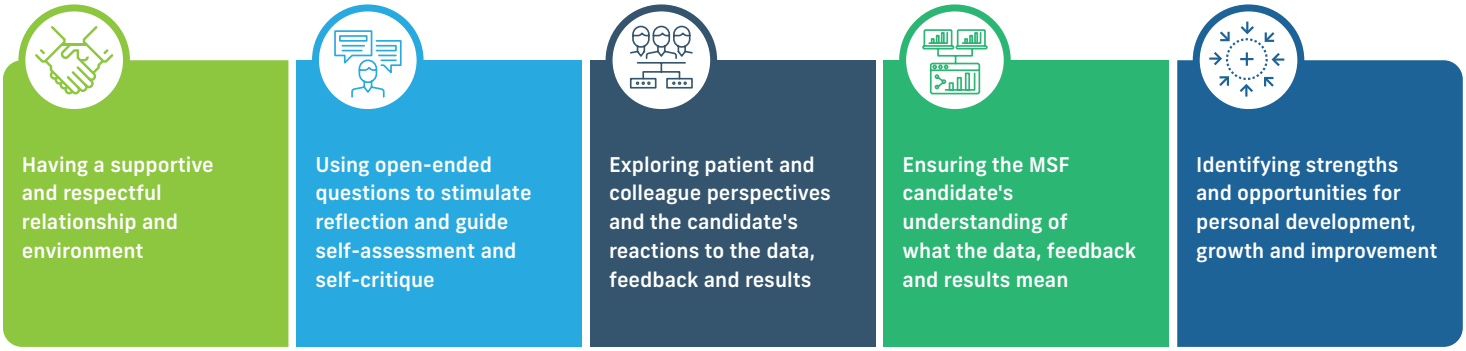


Figure 27: Characteristics of effective feedback conversations.[106-109]
Source: Adapted by CFEP Surveys, 2022.

Facilitated debrief and reflection help the individual candidate to:[5,21,106-110]

- be more aware of the experience of care they provide
- explore reactions to the feedback and better understand it means to them
- translate new information into insights and knowledge about strengths
- identify and implement areas and priorities for personal development, growth and practice improvement.[15,34,101,102]

When conducting facilitated debrief and fostering self-reflection, the facilitator or coach needs to pay attention to the skills required for handling both process and content:[106,110]

- **Process skills include:**
  - reviewing the purpose of the program and session goals with the clinician
  - developing the relationship throughout the session
  - ensuring familiarity with the data
  - using communication micro skills to explore reactions to the results, clarify understanding and provide encouragement through active listening and open questioning
  - promoting reflection and Self-Assessment by bringing blind spots into focus
  - being flexible about the content to be discussed.
- **Content skills include:**
  - collaborating to make sure the clinician is engaged in and committed to the discussion
  - goal setting and developing anticipated outcomes
  - creating a tailored action plan and a follow-up plan to monitor progress and ensure accountability.

Facilitated conversation should focus on the data in each report as well as triangulated data across colleague (clinical colleagues and non-clinical co-workers) and Self-Assessment reports, or benchmarks with other participating clinicians. For example, clinical colleagues may provide high ratings for punctuality and reliability but non-medical co-workers might rate those items lower. The discrepancy may provide an opportunity to ask the clinician about the difference.

Considering the candidate's Self-Assessment report creates space for reflective discussion, especially when the Self-Assessment scores differ from their reviewers' scores.[44] A difference in results creates an opportunity for further exploration.

For clinicians who are excelling, this discussion could focus on an aspirational change or improvement they may wish to make personally, professionally or organisationally.

Figure 28 illustrates the process adopted in this stage.

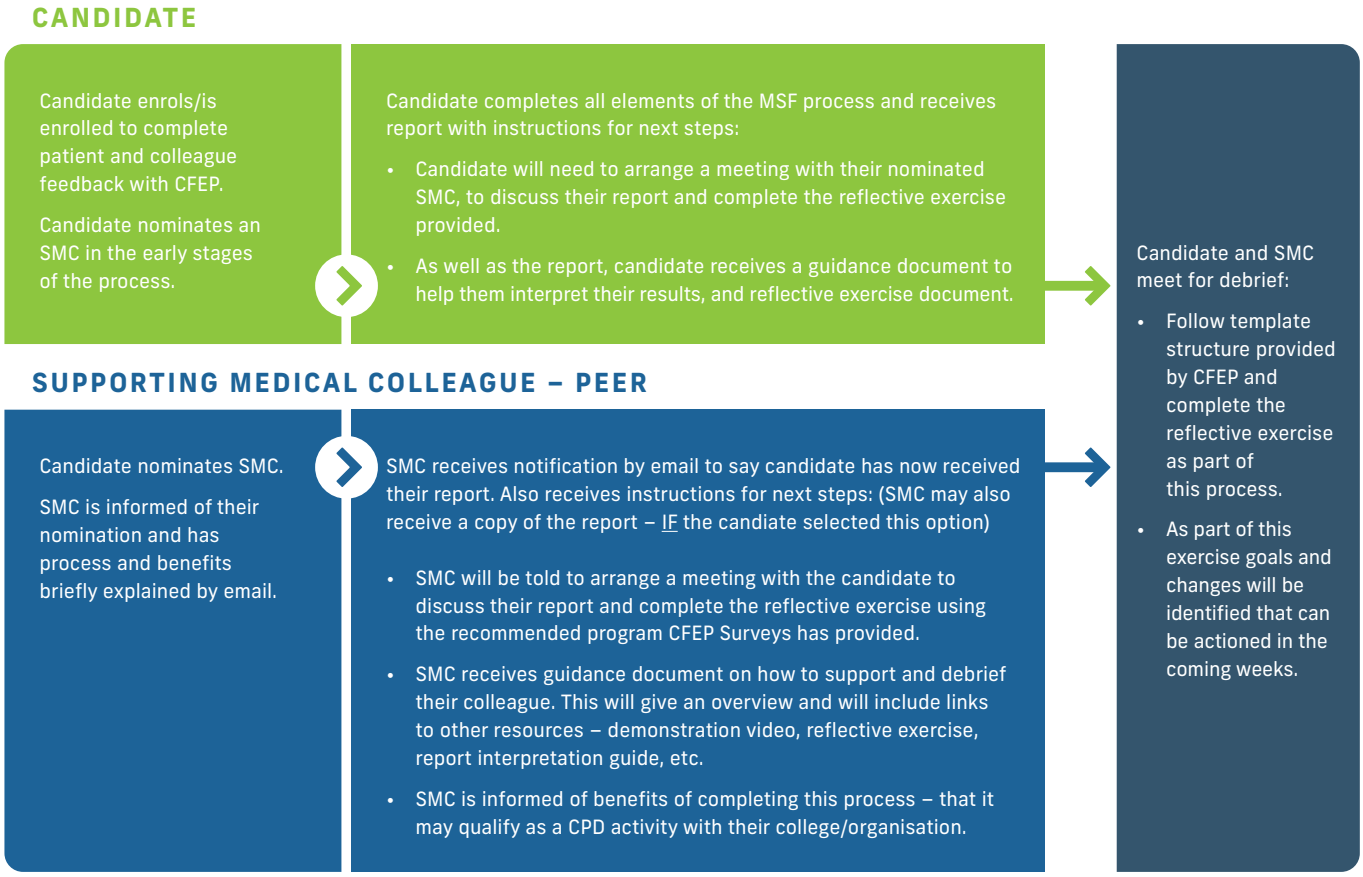


Figure 28: MSF informal debrief and self-reflection process.
Source: Developed by CFEP Surveys, 2022.

Note: The debrief happens before the reflective period and the personalised action plan are completed.

Clinicians have two options for supported debrief and self-reflection:

Debrief	Process
Formal	This is a highly recommended optional service available to any clinician completing the MSF tool in full or part (i.e. patient feedback or colleague feedback and Self-Assessment). It includes a one-hour debriefing phone call or videoconference between the candidate and a trained MSF facilitator or coach (i.e. an experienced member of the CFEP Surveys debrief team).
Informal	This is a debrief conversation between the candidate and their nominated supporting medical colleague, supervisor or medical educator in which both parties discuss the report and its findings.

Table 5: Supported debrief options.
Source: Developed by CFEP Surveys, 2022.

Formal debriefing

CFEP Surveys formal debrief approach adopts the Relationship, Reaction, Content, Coaching (R2C2) feedback model,[21,46,100] a strength-based approach to facilitation and coaching and action planning.

This R2C2 model is founded on three theoretical perspectives – humanism, informed Self-Assessment and the science of behaviour change, and includes four phases:[21,46]

Figure 29: Coaching for performance change: R2C2 model.[21,46]
Source: Adapted by CFEP Surveys, 2022.

Theory and research inform each phase, to guide the feedback conversation and provide open questions to promote self-reflection, self-critique and self-direction. The intention is that the facilitator or coach use the model iteratively, to explore the sections of the report that are most meaningful to the candidate and to the facilitator or coach, and then to coach the individual through the process of co-developing a purposeful action plan.

Facilitated discussion is focused on the data in the MSF report about each of the three MSF roles: communicator, collaborator, professional. In upholding the formative nature of MSF, the facilitator or coach uses a coaching approach where discussions focus on the clinician's relative strengths and improvement areas within each role.

Coaching in the MSF context is considered: *'a one-to-one conversation focused on the enhancement of learning and development through increasing self-awareness and a sense of personal responsibility, where the coach facilitates the self-directed learning of the coachee through questioning, active listening, and appropriate challenge in a supportive and encouraging climate'.*[111]

Some candidates might find considering results challenging. It is important that a skilled facilitator or coach conducts the debrief and understands, plans and prepares for challenges, such as:

- how to manage the session when the clinician hasn't reviewed their data
- how to manage the conversation when the clinician is resistant to change
- how to work with a clinician who is clearly upset by the feedback, or alternatively considers themself an overachiever.

Facilitated coaching conversations may include open-ended questions, such as:[99,101]

- Did you focus on particular sections of the feedback report? If so, please describe which sections you focused on and why.
- What did you learn that was expected or unsurprising? Why was it expected?
- What did you learn that was unexpected or surprising? Why was it surprising?
- What did you find that seemed noteworthy or important? Why was it important?
- Is there a gap between the care you want to offer and what the report suggests?

Completing the MSF tool and this reflection process can contribute to CPD requirements for the candidate and their supporting medical colleague.

For more information about CFEP Surveys formal facilitated debrief services, and to access a range of complimentary debriefing training tools, see **cfepsurveys.com.au/our-surveys/multi-source-feedback/** or speak to the CFEP Surveys team.

Informal debriefing

This debrief conversation is typically conducted between the MSF candidate and their supporting medical colleague – a trusted medical colleague the candidate appoints to support them in this process.

Informal debrief allows opportunity to consider and discuss the report, reflect on results, and establish insights to inform subsequent action planning. In some cases, clinicians on training pathways receive debrief support from their clinical supervisor or medical educator. Alternatively, a medical division or departmental head of service may provide debrief when a participating organisation sponsors the MSF program.

CFEP Surveys does not specify the format for informal debrief and the training provider or sponsoring organisation uses it at their discretion. CFEP Surveys recommends adopting a skilled coaching approach to focus on the clinician's priorities for change, goals for improvement, and co-creating an action plan based on the performance data.[48]

There are a range of complimentary training resources covering MSF and in particular debriefing and the R2C2 model available to support your MSF journey. These include video demonstrations on how to deliver a debrief for candidates who have received both excellent and peer reports, a series of micro-learning videos which cover common debriefing scenarios, 'pearls and tips' and the R2C2 model, and more. These can be accessed at **cfepsurveys.com.au/our-surveys/multi-source-feedback/**.

When conducting informal debrief, we recommend the MSF candidate and their supporting medical colleague establish a shared understanding, outlining those principles and agreements they will uphold during the MSF process; for example:

- **confidentiality** – all data and reports will remain confidential, and discussion during the informal debrief will be conducted in strictest confidence to allow openness and honesty.
- **respect** – respectful consideration will be given to feedback from patients and colleagues, recognising their unique position, the spirit in which the feedback was provided, and a focus on learning to inform professional development, growth and improvement.

Self-reflection

The MSF program aims to normalise the process of professional review and reflection as part of a supportive whole-system learning approach encompassing professional bodies, provider organisations and health care professionals.

The feedback report will also include guidance on conducting a reflective exercise to inform the development of a personalised action plan, plus tools and templates for considering results by source (i.e. patient and colleague) and results overall.

SELF-REFLECTION OF PATIENT FEEDBACK

You will need to complete this reflective exercise and return CFEP Surveys to award you CPD points. You will need to allow 6 to 8 weeks from receiving your feedback before submitting your reflective exercise.

It is important that you discuss your patient feedback and reflection with a colleague, both at the initial review and again 5-8 weeks after. This is to allow you time to implement any actions you have set yourself to achieve after this reflective exercise.

1. Why did you choose to undertake this CPD Accredited Activity?

2. How would you rate following learning outcomes?

	Not Met	Partially Met	Entirely Met
a) To differentiate between effective and poor communication skills in the consultation	☐	☐	☐
b) To assess your communication skill competency by comparing yourself to benchmarks against other GPs	☐	☐	☐
c) To generate areas of improvement in your communication skills based on the results of the patient feedback report	☐	☐	☐
d) To analyse the CFEP ready-reckoner tool to enhance patient safety through improved communication skills	☐	☐	☐
e) Modify your communication skills based on discussions with another colleague about the results of the patient feedback	☐	☐	☐

3. Please rate to what degree your learning needs were met

Not Met	Partially Met	Entirely Met
☐	☐	☐

4. Please rate to what degree this activity is relevant to your practice

Not Met	Partially Met	Entirely Met
☐	☐	☐

5. Look at your overall patient ratings for each question and determine:
a) What are your four (4) highest scoring questions? Are you pleased with these scores and why?
b) What skills are tapped by these questions?
c) Are these the areas you would have predicted to be rated most highly? Why?

1.

2.

3.

4.

CFEP SURVEYS

1

Figure 30: Example, Self-reflection and action planning template – patient feedback.
© CFEP Surveys

SELF-REFLECTION OF PATIENT FEEDBACK

6. Look at your overall patient ratings for each question and determine: **a) What are your four (4) lowest scoring questions? Are you pleased with these scores and why?** **b) What skills are tapped by these questions?** **c) Are these the areas you would have predicted to be rated least highly? Why?**
1.
2.
3.
4.

7. Reflect on the patient breakdown of your sample (i.e. gender and number of visits): **a) Are the ratings given by one group consistently higher than the ratings of the other groups?** **b) Which group do you feel most comfortable with and why? Is this reflected in your scores?** **c) Which group do you feel least comfortable with and why? Is this reflected in your scores?**

8. Now look at the Interpersonal Skills Ready Reckoner. Having reflected on the feedback from your patients: **a) Which three (3) interpersonal skills would you like to practice over the coming weeks?** **b) What factors might get in the way (e.g. time pressure) and how will you overcome these?**
1.
2.
3.

CFEP SURVEYS

2

Figure 31: Example, Self-reflection and action planning template – patient feedback.
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SELF-REFLECTION OF PATIENT FEEDBACK

9. After a period of 6-8 weeks of practicing skills from the Interpersonal Skills Ready-Reckoner, what differences have you noticed in your interpersonal skills and the impact they have had on your patients?

10. We would appreciate your comments on how we could improve the content and format of the results or if there is any further information you would like to receive.

11. Who did you discuss your results with?

12. What did you learn from this discussion?

I confirm that _____
(name of candidate)

has participated in an initial reflection discussion and completed the GP Report Review.

Colleague Name: _____
Signature: _____
Date: _____

has participated in a follow up discussion after a 6 – 8-week period.

Colleague Name: _____
Signature: _____
Date: _____

Name: _____ **Signature:** _____
RACGP CPD ID No: _____ **Date:** _____

Please return form to:
Mail: PO BOX 588, EVERTON PARK, QLD 4053
Email: info@cfepsurveys.com.au

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3

© CFEP Surveys 2022

Figure 32: Example, Self-reflection and action planning template – patient feedback.
© CFEP Surveys

The recommended time for completing the self-reflection exercise is immediately following the debrief, and should be continued to be worked on and adapted by the candidate throughout the 4-6 week period of self reflection where the candidate trials new ways of working based on the feedback received and strategies discussed during the debrief. The supporting medical colleague or medical educator may participate in this activity, informally reflecting on the candidate's results and providing additional insight and support to them.

Completing self-reflection helps the candidate to prioritise areas for personal development, growth and improvement and develop the action plan. Once the candidate submits the completed reflective exercise to either the participating medical college or CFEP Surveys, they can receive CPD recognition.

MULTI-SOURCE FEEDBACK REFLECTION GUIDE AND ACTION PLAN

Name _____

Signature _____ **Date** _____

Please utilise this document to support you in undertaking a comprehensive analysis of your personalised report findings. We suggest you review you work your way through your patient feedback results followed by your colleague feedback.
The purpose of this document is to assist you in gaining a greater understanding of the feedback provided to support you in identifying areas of strength and professional development opportunities. We hope you find this process helpful.
It is important that you discuss your patient feedback and reflection with a colleague, both at the initial review and again 5-8 weeks after. This is to allow you time to implement any actions you have set yourself to achieve after this reflective exercise.
You will need to complete this reflective exercise and return CFEP Surveys to award you CPD points.

Why did you choose to undertake this activity?

Please rate to what degree the following learning outcomes were achieved?			
Patient Feedback	**Not Met**	**Partially Met**	**Entirely Met**
a) Differentiate between effective and poor communication skills during a patient consultation	☐	☐	☐
b) Assess your communication skill competency by comparing yourself to benchmarks against other doctors	☐	☐	☐
c) Identify areas of improvement in your communication skills based on the results of the patient feedback report	☐	☐	☐
d) Analyse the CFEP Interpersonal skills ready-reckoner tool to enhance patient safety through improved communication skills	☐	☐	☐
e) Modify your communication skills based on discussions with another colleague about the results of the patient feedback	☐	☐	☐
Colleague Feedback	**Not met**	**Partially met**	**Entirely met**
f) Distinguish between effective and poor professional skills as determined by the items in the colleague feedback evaluation tool	☐	☐	☐
g) Analyse what you do well and can improve upon, based on the results of the colleague feedback report	☐	☐	☐
h) Determine how to improve your non-technical skills by reviewing your feedback in alignment with the Surgical Competence and Performance Guide.	☐	☐	☐
i) To modify your professional behaviour based on the results of your discussions with a trusted colleague	☐	☐	☐

CFEP SURVEYS

Figure 33: Example, Self-reflection and action planning template – 360-assessment.
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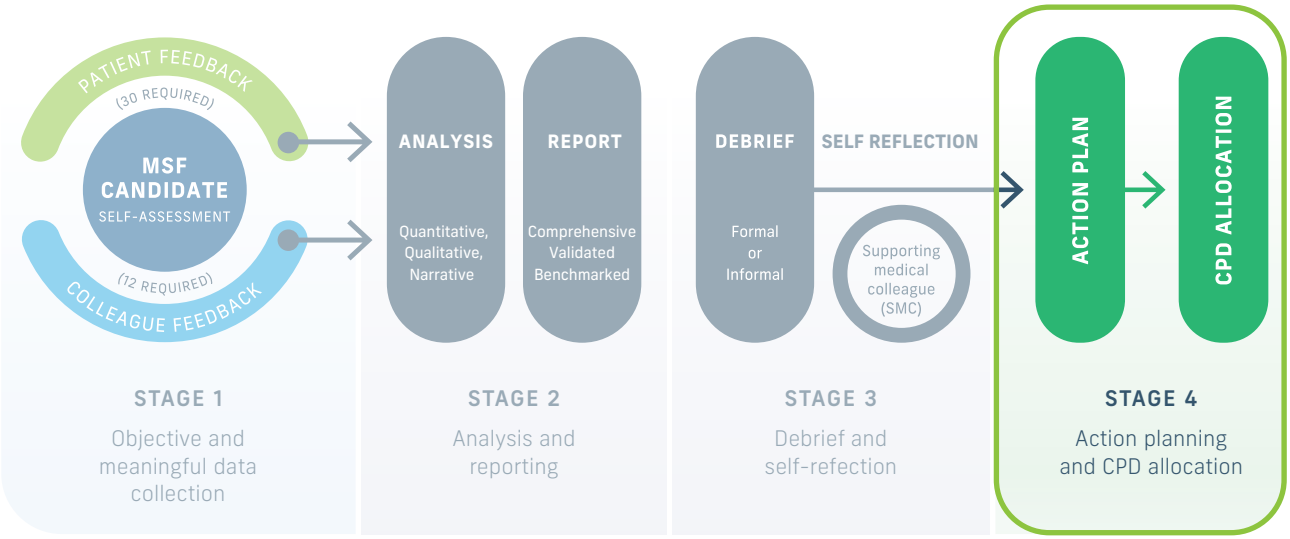
Stage 4 – Action planning and CPD allocation



The MSF process culminates in the co-development of goals for personal development, growth and improvement, and an evidence-informed action plan.[4–7]

Co-development is critical to the action plan's success. The candidate must make the major contribution and feel they own their personalised action plan, while the coach contributes their experience and knowledge and facilitates the process and content development. The role of the formal debrief coach is not to provide answers or solutions, but to help prioritise areas for improvement, goal setting, opportunities and strategies for professional development, growth and improvement and to help document agreed changes in an annual action plan.

Research suggests action plans and anticipated outcomes are more likely to be achieved when co-developed, as opposed to being developed by only the candidate, facilitator or coach, or medical director.[28,54,58,59]

Figure 34 shows the process adopted in this stage.

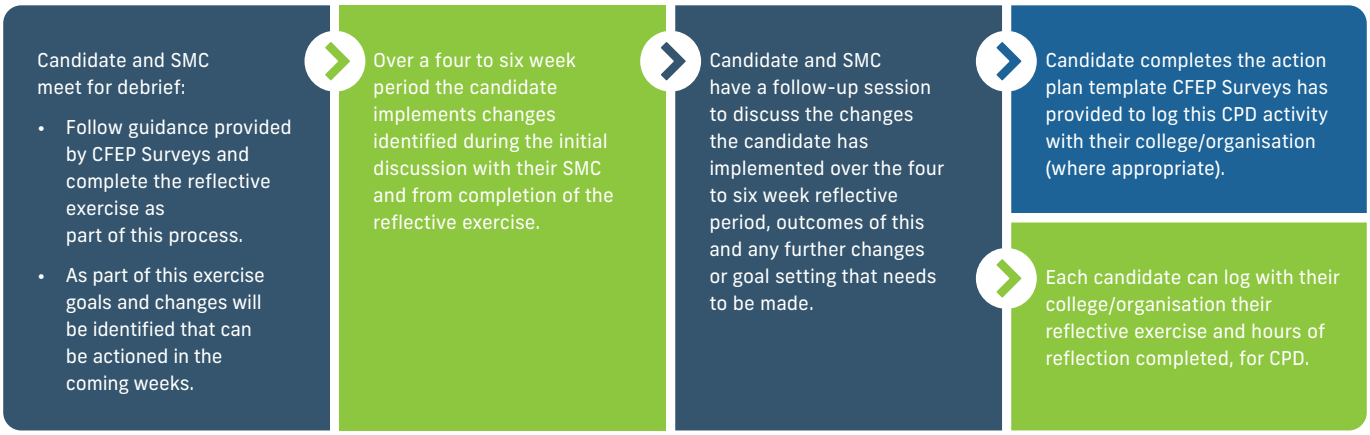


Figure 34: MSF action planning process and CPD allocation.[4–7]
© CFEP Surveys

During the action planning process, the facilitator or coach may also connect the MSF candidate with learning resources and system supports to help them achieve their improvement goals. When collaborating with professional and peak bodies, education and training institutions or CPD units, CFEP Surveys will provide a list of such resources.

Informed by MSF results and insights from the facilitated debrief session, the action plan describes the changes the candidate intends to make in the short-term (over the next six to eight weeks) and across the medium term (over the next six to 12 months). It also captures initial activity required for longer term goals (12-plus months).

CFEP Surveys action plan template outlines a structure in which the candidate can capture information about:

- resources they need to support the changes
- the enablers and barriers to change
- what success looks like
- how and when they will know they have achieved success.

An action plan example, articulating one meaningful goal, is provided in Figure 35. CFEP Surveys suggests the candidate create up to three targeted goals to work on during the annual MSF cycle. They might struggle to achieve any more would in the time available.

DESCRIBE A SPECIFIC OBSERVABLE CHANGE THAT YOU INTEND TO MAKE AS A RESULT OF THE FEEDBACK.

I will get my clinical notes and dictations completed by the end of each clinical session and as close to real time as possible.

WHAT IS YOUR GOAL?

I will improve the timeliness and accuracy of case notes and written information in order to safeguard patient care.

SPECIFICALLY, IDENTIFY WHAT YOU WILL DO.

I will enter clinical notes into the electronic patient record when consulting the patient.

I will dictate GP letters in real time when consulting the patient. When doing so, I'll ask patients to stop me if they don't understand what I have said and correct me if they think what I have dictated is not what we discussed or agreed. I will hand a copy directly to the patient.

HOW WILL YOU AND YOUR PATIENTS BENEFIT FROM THIS CHANGE?

All patient records will be up to date, accurate and relevant.

Patients will feel they are active participants in their care and care planning.

The real-time dictation process will:

1. help increase health literacy levels among my patients, reinforcing the significance of the clinical tests and results, providing opportunity to identify and query those matters they don't fully understand, document the options they have and actions we have agreed, increase confidence in the fact they have the same information as me and their GP, and reinforce the importance of them visiting their GP for any ongoing care
2. hold me accountable and allow the patient to challenge should they misunderstand what is said or they think I haven't communicated effectively, or where there is a discrepancy between what we discussed and what I thought we had discussed
3. allow me to complete sessional work in each session and not stress about the fact I have clinical notes to update of an evening.

Figure 35: Action plan example.
Source: Developed by CFEP Surveys, 2022.

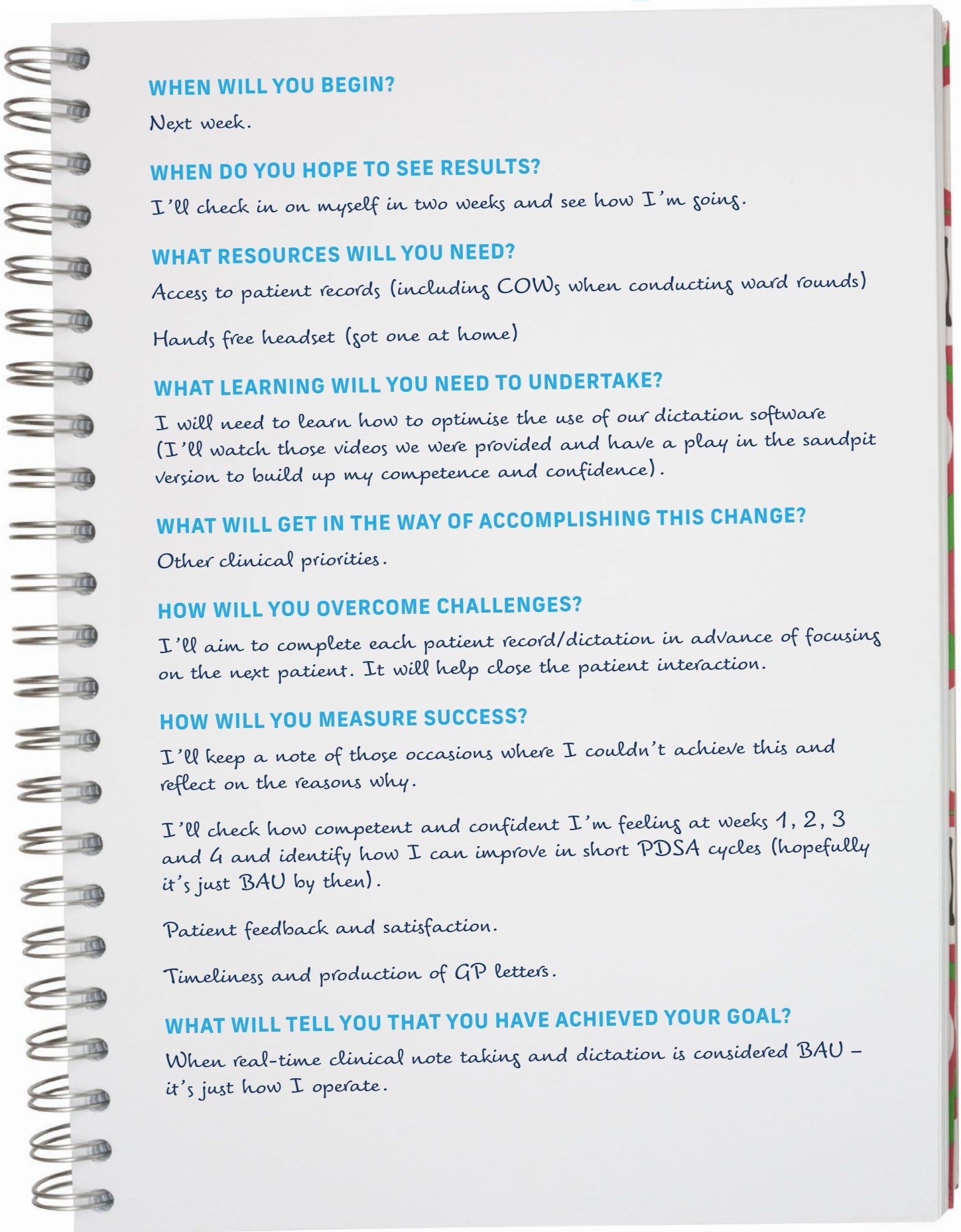


Figure 35: Action plan example.
Source: Developed by CFEP Surveys, 2022.

We highly recommend the candidate and the supporting medical colleague hold a follow-up facilitated coaching session one to two months following development of the action plan, to reflect on the impact of the changes made in the short-term.

The true value of the MSF process is realised as candidates embed learnings into improved patient experience of care, clinical practice, and collegiate relationships.

CFEP Surveys provides templates to support short-term review processes. Some participating organisations, colleges and training pathways, and CPD homes will require the candidate to return their completed action plan before they will recognise completion of the MSF process. In other instances, the candidate can return the action plan to CFEP Surveys.

CFEP Surveys provides a certificate of completion, demonstrating self-evaluation, performance review and outcomes measurement-related activity (as appropriate), as per the MBA's CPD standards and associated requirements.

The MSF process may conclude in this annual round, with the candidate and supporting medical colleague logging CPD activity with their professional and peak body, college, CPD home, or sponsoring organisation as appropriate.

Note: Professional development and improvement-related activity undertaken in line with the action plan may attract additional CPD recognition. It is important that candidates log and self-evaluate these personalised professional development, growth and improvement activities and self-evaluate these activities.

CFEP Surveys MSF tool provides an annual cyclical process of reviewing performance, measuring outcomes, and self-evaluation. Once the candidate has completed the action plan, CFEP Surveys recommends they repeat the virtuous cycle of MSF to engender a culture of excellence, demonstrate leadership, and sustain their personal development, growth and improvement.

The MSF tool fits readily into the annual CPD cycle for all health care professionals

The practice of using qualitative and quantitative data, together with constructive feedback, to guide learning, professional development, growth and improvement is integral to all healthcare professional development programs.

Typically, national professional standards and regulatory frameworks, alongside service standards,[112,113] recognise the role that personal performance and practice assessment play in ongoing improvement. The MSF tool provides objective performance data using external sources of data and multiple feedback mechanisms together with Self-Assessment to inform the development of a personalised action plan. This plan is data-informed and follows a reflective period where MSF candidates trial and embed changes to clinical practice and service delivery.

The MSF tool fits readily into the annual CPD cycle for all health care professionals, providing objective data they can use when creating and implementing an evidence-informed learning plan and evaluating performance and outcomes.

CFEP Surveys MSF tool is consistent with the Medical Board of Australia's *Continuing Professional Development (CPD) registration standard*, effective January 2023.[90] This standard requires clinicians to develop and complete a personalised annual professional development action plan, emphasising performance review (i.e. MSF – colleague feedback component) and measuring outcomes (i.e. MSF – patient feedback component), and Self-Assessment of CPD activities to inform planning for the following year.

The Australian Health Practitioner Regulation Authority (AHPRA), many of Australia's medical colleges, and healthcare professional and peak body organisations, have approved the MSF tool, and made available a range of CPD allocations. Please contact CFEP Surveys or your medical college to ask about access to MSF and current CPD allocations for your specialty when completing MSF or components of it (i.e. patient feedback and/or colleague feedback and Self-Assessment and associated reflection and action planning).

Glossary

Term	Description
360-degree feedback	A system in which anonymous feedback is gathered about an individual from various people they have working relationships with. Extensively used in industry, this usually encompasses managers, peers, direct reports, subordinates: hence the name '360-degree'. The system is used extensively as a development tool because it provides information about a subject's work competencies, behaviour and working relationships. It's also mainly used for individuals higher up in the organisation's hierarchy.[114]
Clinical colleagues	Those clinicians you collaborate at your micro system level to accomplish person-centred team-based care (e.g. nurses, pharmacists, dieticians and other health care professionals who you identify to complete the surveys).
Collaborator	As collaborators, clinicians work effectively with other health care colleagues (i.e. clinical colleagues and non-clinical co-workers) to provide safe, high-quality, patient-centred care.
Communicator	As communicators, clinicians form relationships with patients, carers and families that facilitate the gathering and sharing of essential information for effective health care.
Facilitator or Coach	A facilitator enables or guides individuals or a group in exploring or undertaking an activity. A coach in education plays a similar facilitative role in guiding an individual to identify performance improvement goals and in co-developing an action plan to meet these goals. We use the term 'facilitator or coach' to emphasise both the facilitative and outcomes-focused aspects of the role in the application of MSF.[5]
Formative assessment	Providing assessment data for learning (i.e., for the individual to use for his/her own learning and improvement).[5]
Instruments	The three feedback survey tools used in MSF assessment: • Interpersonal Skills Questionnaire – patient feedback • Colleague Feedback Evaluation Tool – colleague feedback (i.e. clinical colleague or non-clinical co-worker) • Self-Assessment tool – MSF candidate feedback.
Items	Individual questions used in the MSF instruments.[5]
MSF candidate	The individual health care professional undertaking the MSF formative assessment.[5]
Non-clinical co-workers	Those non-clinical co-workers you collaborate with at your micro system level to accomplish person-centred team-based care (e.g. reception and administrative staff, porters, cleaning staff etc.)

Term	Description
Person-centred care	Personalised care that encompasses the following dimensions: respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, involvement of carers and family, and access to care.[115]
Professional	As health care professionals, clinicians are committed to the health and wellbeing of individual patients and society through ethical practice, high personal standards of behaviour, accountability to the profession and society, clinician-led regulation, and maintenance of personal health.
Reviewers	Individuals who complete surveys about the health care professional being assessed: clinical colleagues, non-clinical co-workers, and patients.[5]
Summative assessment	Providing assessment data for evaluation purposes (i.e. for the individual's institution or organisation to make high-stakes decisions about his/her performance.[5]
Supporting medical colleague (SMC)	A trusted medical colleague able to provide informal debrief and support to the candidate when they're reflecting on strengths and opportunities for improvement and planning for change.[5]
System	A network of interdependent components that work together to accomplish a shared aim.[116] The system has 3 levels: • *micro system* – small, interconnected individuals and frontline teams of clinical and non-clinical staff and consumers who work together to achieve both clinical and organisational aims – the place where patients and their families and clinicians actually meet • *meso system* – mid-level systems that promote alignment and linkages between two or more clinical and supporting microsystems that tie consumers, health professionals, teams and services together, connect clinical aims and direct care at the frontline with strategic goals, business aims and executive work at the macro level • *macro system* – the overarching healthcare organisation of interdependent micro and meso systems to address consumer and customer needs (e.g. a general practice, a hospital, a residential aged care facility, or an integrated health system such as a chronic disease pathway).
Team-based care	The provision of comprehensive health services to individuals, families, and/or their communities by at least two health professionals who work collaboratively along with patients, family caregivers, and community service providers on shared goals within and across settings to achieve care that is safe, effective, person-centred, timely, efficient, and equitable.[117]

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The CFEP Surveys team is passionate, driven and deeply connected to both the patient and the clinician journey. We are committed to closing the loop on health care outcomes and experience through a range of practice, patient and clinician feedback tools to support incremental change while working towards professional development, growth and improvement, and healthcare transformation.

For more information about MSF and a range of patient reported experience measures (PREMs) and patient reported outcome measures (PROMs), including the Patient Activation Measure® (PAM®), contact us:

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