Service continuity and clinical governance support. A role for regional GP relievers?

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Abstract

The presentation will describe how the role of Relieving GP has developed in the context of a regional Aboriginal Community Controlled Health Organisation (ACCHO).

The GP reliever is a full-time employee of the Organisation and provides, during periods of recreational or study leave, continuity of service by a doctor familiar with local medical software, policies, procedures and (often) prior experience of working with resident staff and Community.

The position is combined with that of medical educator. This ensures continuity of supervision for GP registrars whilst creating opportunities for quality improvement activities including peer coaching and review.

The model is an alternative to employing high cost, short-term locums with additional benefits for organisational and clinical governance which can be shared at regional level.

Introduction

The Priority Recommendations from the 13th National Rural Health Conference (National Rural Health Alliance, 2015) include:

- an implementation plan for the National Aboriginal Health Strategy
- capitalising on local knowledge and capability
- alternative approaches to service delivery and organisational governance
- health workforce development including CPD, mentoring and increasing scope of practice.

Bridging the gap between aspiration, strategy, recommendations and practice is the domain of Quality Improvement (QI).

A quality health care system has been defined as being both accessible and effective (Campbell et al., 2000) and the enhancement of quality as the “translation of values into practices” (Bleakley et al. 2014).

For patients, this means access to services providing effective treatment at the time of need.

For populations, it is expressed as equitable access to services and interventions that optimise the health and well-being of the whole community.

Described in this way, improving quality of care can be seen as a form of social justice, something which resonates with many health professionals.
However, the narrative accompanying the proliferation of frameworks, journal articles and evidence based guidelines published in the name of quality improvement has been characterised by:

- imperatives for efficient use of resources
- risk aversion triggered by an increasingly litigious society
- a political backdrop of fiscal constraint
- new requirements for professional regulation and revalidation triggered by evidence of variations in the provision of care and associated health outcomes (Australian Institute of Health and Welfare, 2008)

Such forces introduce tensions to the pursuit of quality in health care and health professionals’ perceptions of it. The unease is epitomised by debate about whether quality is related to the achievement of minimum standards (fitness for purpose) or the pursuit of excellence and whether quality assurance in health care is about managing expectation or addressing aspiration.

Here, I introduce the concept of Continuous Quality Improvement (CQI) in health care.

CQI is a management philosophy developed by Stewhart in the U.S. in the 1930s (Radawski, 1999). The concept was successfully applied in Japanese manufacturing from the 1950’s and accompanied a rapid transformation in the quality and quantity of Japanese goods sold worldwide.

A central tenet of industrial CQI is that a poor quality product is the result of poor job design, failure of leadership, unclear purpose or a combination thereof. Furthermore, production processes yield data which can be harnessed to fuel reflection and clarify changes required to improve quality. It is an iterative process (in Japanese: kaizen) in which there is a continuous drive to improve.

Donald Berwick, a Harvard Community Health physician was one of the early advocates of the introduction of CQI theory into health care (Berwick, 1989). CQI theory is a form of social learning theory which asserts that learning involves changes in cognition which arise from interactions between personal, behavioural and environmental factors (Levato and Wall, 2014).

Prior to the widespread availability of computers Berwick recognised the usefulness of data generated during the delivery of health care and the need to interpret it effectively. He also championed a collaborative approach between managers and health workers and argued for dialogue with service users. He recognised the need to work in teams in response to issues of complexity and to eradicate the isolation of the “sole practitioner”.

Detractors of the adoption of CQI theory in health care pointed out that patients require individualised care rather than industrialised ‘processing’. However, in a health context, it is patient access and system effectiveness rather than process efficiency that are the focus for CQI.

Meanwhile those concerned with upholding professional standards argued that CQI is incapable of identifying ‘bad apples’ by assuming all practitioners are virtuous.

It is worth noting that the eradication of ‘bad apples’ is not the purpose of CQI. This is the domain of professional regulation. CQI focuses on system analysis and consciously avoids scrutiny of individual performance.
Health professionals may worry that openness about defects or errors leaves them open to litigation. However, experience is that discussion of patients’ journeys through systems and the problems they encounter along the way produces positive responses and reduces the likelihood of litigation particularly if there are grounds for complaint. The alternative is to assume personal responsibility for defects or errors in our systems by recognising them but failing to act.

Almost a decade after Berwick’s efforts in the U.S. the term “clinical governance” (CG) was introduced in the UK to describe the way “organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence and clinical care will flourish” (Scally and Donaldson, 1998). Organisational culture, leadership and teamwork were introduced as key ingredients supported by quality data and scientific evidence to both inform practice and address poor performance.

Professional development underpins clinical governance confirming that CQI is itself something to be learned and refined.

This leads me, as a medical educator working as a GP in Aboriginal Primary Care, to ask if CQI can also be taught, nurtured, facilitated and assessed.

Having made this connection I shall now consider CQI as a focus for my role as a medical educator and GP in an Aboriginal Community Controlled Health Organisation.

I shall also compare and contrast the evidence in my own context with that of school teachers. I have chosen this professional group because there are parallels between a pupil’s safe and effective journey through the education system and that of a patient accessing health care.

The role of a regional relieving GP

In South East Queensland, The Institute for Urban Indigenous Health (IUIH) is an Aboriginal Community Controlled Organisation formed by 5 Member Services and encompassing 18 primary health clinics located within the footprint of 4 Primary Health Networks (PHN).

The region has one of the Australia’s fastest growing Aboriginal populations with projections to reach 130,000 by 2030.

IUIH provides allied health and specialist services for its Members and leads the development of new programs and resources, fostering integration with existing medical and social health agencies. IUIH’s growth has been accompanied by the development of robust clinical governance processes and a strong emphasis on the routine use of data as part of CQI.

IUIH employs 3 full-time equivalent regional GP relievers. All are vocationally registered with The Australian College of Rural and Remote Medicine (ACRRM) or The Royal Australian College of General Practitioners (RACGP).

GP relievers provide short- and medium-term locum tenens. They cover periods of recreational and study leave and can provide an extra pair of hands during periods of high demand such as local festivals or holidays. They may also back-fill for permanent GPs performing tasks such as medical audit and peer review.

At IUIH, the position of regional relieving GP is combined with that of medical educator, responsible for facilitating CQI and CG processes.
These roles are complementary because, by regularly visiting locations in a regional relieving capacity, the facilitator becomes familiar with local policies, procedures and skill mix and is better able to negotiate CQI barriers and enablers mentioned hereafter.

**Why should medical and other health professional educators facilitate and teach CQI?**

Papanicoulaou (PAP) smear screening is recommended for most women every 2 years until age 70. There is clear evidence of effectiveness in preventing cervical cancer. In Australia around 68% of women have had the test in the last 2 years and we have the second lowest mortality rate for cervical cancer of any country (Australian Government National Health and Medical Research Council, 2005). However, inequalities exist in access to screening.

The National Key Performance Indicators (nKPI) for Aboriginal and Torres Strait Islander Primary Health Care indicate Aboriginal women have higher rates of cervical cancer and lower rates of screening (around 31%).

Figure 1 is an excerpt from the 2015 Australian Institute of Health and Welfare (AIHW) nKPI report showing national PAP smear screening rates for Aboriginal women between June 2013 and December 2014.

**Figure 1**

![Cervical screening, by reporting period](image)


PAP smear data from 233 organisations is collected twice a year and reported to AIHW where it is collated and analysed. Service level reports are despatched to every organisation with an accompanying PowerPoint presentation for staff and suggestions of how to increase PAP smear uptake.

There has been no improvement in national rates of PAP smear recording for Aboriginal women since reporting began.

This isn’t the whole story. A subsequent table illustrates wide variations in the uptake of PAP smears amongst Aboriginal women which do not correlate with geographical location or organisational size as shown in Figure 2.
According to CQI theory and the preceding definitions of quality, a collaborative change to the design of local systems with a focus on improving access to PAP smear testing will improve uptake in a way that simple reporting/feedback of data has failed to achieve.

There is accumulating evidence that this can occur (Dorrington et al., 2015)(Marley et al, 2013) (Panaretto, et al., 2013) and further evidence that increased rates of PAP smear uptake are strongly associated with service participation in CQI processes (The Australian Institute of Health and Welfare, 2015).

In services without CQI there is a need for education to promote CQI theory and overcome barriers to implementation. In services where CQI has begun there is a need for ongoing facilitation to ensure the process continues (Doran Irvine, 2002)

**Barriers and enablers to CG and CQI**

Five key attributes have been identified for successful implementation of CQI in Aboriginal and Torres Strait Islander primary care (Lowitje Institute, 2015):

- client and community focus
- leadership
- organisational CQI culture
- team function
- systems thinking.

These align strongly with CQI theory and the definition of clinical governance.

Recent evidence from 73 ACCHS has shown no correlation between CQI performance and population size, remoteness, governance model or accreditation status (Larkins et al, 2016). These findings are also consistent with CQI theory where organisational commitment, leadership and teamwork are more important than organisational size, location or sophistication

Further insight is gained from a Canadian study of secondary care based CQI activities which demonstrated that teams functioning well at the start of the research project were more successful at
implementing a CQI framework. However, even if implementation stalled, participation in CQI appeared to improve teamwork.

**CQI: an example from Aboriginal health**

Figure 3 illustrates the impact of CQI to influenza vaccination rates in four Aboriginal Community Controlled Health Service (ACCHS).

Since 2015 clinic teams have met in March to **Plan** how they will offer all eligible clients access to influenza vaccination when the vaccine becomes available in April.

Each member of the team knows what they must **Do** to implement the plan.

Tracking data is regularly fed back to managers and staff to **Study** progress.

Clinic teams **Act** on the data to continuously improve uptake of the vaccine.

That completes the **PDSA** cycle until its next iteration the following year.

**Figure 3.**

Increased uptake of influenza vaccine by clients aged 50 years and over in Clinics A and D between 2014 and 2015 were sustained in 2016. National influenza vaccination rates did not change over the same period and have yet to be published for 2016.

Clinics B and C did not show a major increase in the uptake of vaccine over a 2 year period.

The data provides useful information for managers and clinic teams preparing for the 2017 vaccination season.

Medical educators will ask how to facilitate increased uptake of influenza vaccination in Clinics B and C and whether sharing strategies used in Clinics A and D will produce similar results elsewhere.

**CQI: an example from school teacher training**

In the 1980s, evidence emerged that school teachers trained in methods proven to enhance lesson delivery had difficulty implementing them upon return to the classroom (Becker et al., 2013). In the U.S., the profession introduced peer-coaching as a way of bridging the gap between evidence and practice.
Like CQI, peer coaching is a form of social learning. It is a reflective and iterative process involving setting goals, observation of a task, peer feedback and support to implement change. The focus is not the acquisition of new knowledge but the activation and application of what is already known (Schwellnus, 2014). Peers with similar or unequal knowledge and experience may work in pairs or form small groups.

Results of peer coaching in education have been impressive with research from the 1990’s indicating the transfer of skills from the training room to the classroom increased from 15-20% to 95% (Schwellnus, 2014). Evidence has emerged that by discussing their performance in a peer coaching environment, teachers practice new skills more frequently and appropriately even if the peer coach is not an expert in the topic.

Peer coaching has yet to gain a foothold in medical education but lends itself to primary health environments where ‘peers’ from different professional and cultural backgrounds can each provide fresh insights into the other’s practice.

**CQI: what to teach and how**

The pioneers of clinical governance and CQI in healthcare saw them as underpinned by education and professional development (Scally and Donaldson, 1998), (Berwick, 1989).

This prompted the introduction of quality improvement into undergraduate and postgraduate health care curricula. To date, there is no consensus about what to teach at each stage of training leading to huge diversity in curriculum content (The Health Foundation, 2012).

The evidence for CQI teaching strategies in 367 health related journal articles has been reviewed (The Health Foundation, 2012). Key findings included:

- It is possible to influence knowledge, skills and attitudes towards CQI through training
- There is no clear evidence CQI improves health outcomes (yet).
- Didactic teaching alone is less effective than methods encouraging active participation
- Online and distance learning are popular and effective if combined with face to face tuition
- Mentors, supervisors, audits and feedback do not produce sustained changes in CQI skills or behaviour except as components of broader training programs
- Inter-professional collaboration shows promise for learning and implementing CQI.
- There are gaps in knowledge about who benefits from CQI teaching; when CQI should be introduced to professional training and how regularly training should be refreshed and reinforced.

**Summary and conclusions**

The origins of CQI theory lie in efforts to improve industrial and commercial processes in the 1930s. Implementation of the theory began in the 1960s in Japan but uptake in health care has been slow despite growing evidence to support its application.
The role of medical education in CQI is to:

- support the acquisition of CQI knowledge and skills
- foster attitudes and behaviours required to successfully implement CQI processes
- facilitate that process through its iterations
- maintain focus on improving patient access and increasing clinical effectiveness
- avoid scrutinising individual performance
- embed programs in social learning theory
- critically appraise CQI processes.

By regularly visiting clinics and working alongside colleagues from a variety of disciplines a GP reliever is well-placed to facilitate CQI and CG through local knowledge and collaborative relationships.

Recommendations (elaborating on the priorities of the 13th National Rural Health Conference)

- An Implementation Plan for the National Aboriginal Health Strategy and the draft National CQI Plan for Aboriginal and Torres Strait Islander Primary Health Care 2015-2025
- Capitalising on local knowledge and capability through multidisciplinary team-based CQI
- Alternative approaches to service delivery and organisational governance using a regional approach to CQI and CG activities
- Health workforce development including CPD, mentoring and increasing scope of practice using a locally driven organisational competency and capability frameworks.

References


**Presenter**

Richard Mills trained as a biochemist and worked for a biotech company in the 1980s before studying medicine at Southampton University in the UK. He became a general practitioner in 1992 and spent the next 15 years working in a semi-rural location in the south of England. He was attracted by working in a multidisciplinary team with access to a local ‘cottage’ hospital and maternity unit. He also developed an interest in medical education and GP training.

In 2008 he took a sabbatical and was invited to work for the Aboriginal Community Controlled Health Service (ACCHS) on North Stradbroke Island in Queensland. The sabbatical lasted somewhat longer than expected and after almost five years on ‘Straddie’ he took up a post as GP/Medical Educator for the Institute for Urban Indigenous Health where he has assisted in the successful expansion of GP registrar training and supervision in ACCHS across the south-east corner of the State. In 2016 he completed a Graduate Certificate in Health Professional Education at Monash University and enjoys blending general practice with a regional role in facilitating continuous quality improvement in a rapidly evolving inter-professional, cross-cultural environment.