



RACGP

*General practice
management toolkit*

Clinical governance

Module

12

General practice management toolkit: Clinical governance

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Foreword

The RACGP's *Standards for general practices* (4th edition) (the Standards) describes quality improvement activities as activities, undertaken within a general practice, where the primary purpose is to monitor, evaluate and improve the quality of healthcare delivered by the practice.

The Standards also recommends practices engage in quality improvement activities that review structures, systems and processes to identify opportunities to increase the quality and safety of patient care.

This module aims to help Australian general practices develop greater awareness and control over what must be done – as well as when, how and by whom it should be done – in order to continuously monitor and improve their clinical practices and the resulting service quality, treatment outcomes and patient experiences.

However, it is not an exhaustive resource on clinical governance. Practices are encouraged to use it as a framework to guide further exploration of this important topic.

Introduction

For the purpose of this module, clinical governance is defined as a 'systems approach' to continuous quality and safety improvement, for which GPs and all practice staff share responsibility and accountability for agreed outcomes.

General practices with effective clinical governance arrangements typically have supportive, open and inclusive cultures in which education, professional development, research, and sharing good ideas and practices are valued and commonplace.¹

They are led by strong clinical leaders who can take ownership of the process, model good practice, challenge poor practice and inspire others.² There is clear assignment of roles, responsibilities and accountabilities for achievement of agreed outcomes and individual and collective performance is proactively managed.³

Finally, the impact on patient care and treatment outcomes is monitored through clinical audit,⁴ risk management and patient–carer consultation.⁵ All lessons learnt inform further quality and safety improvements.

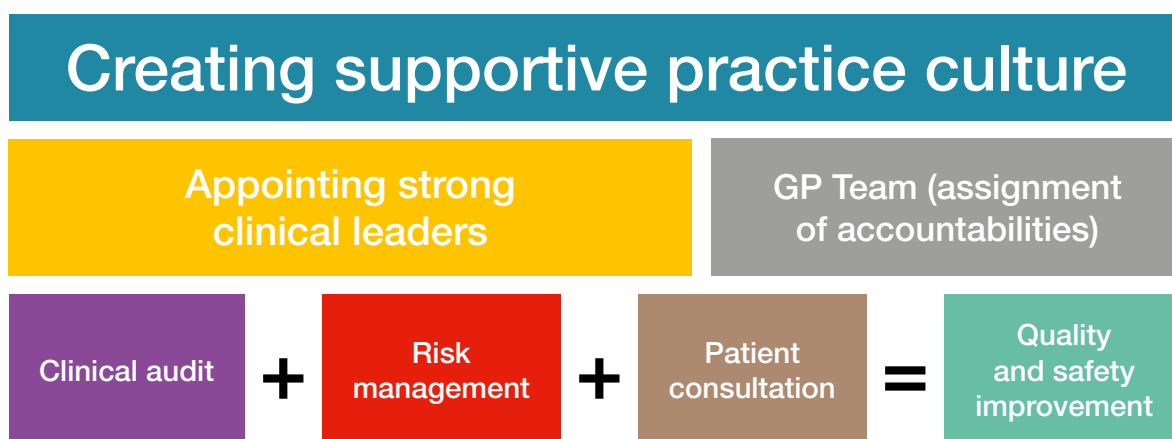


Figure 1. Key clinical governance activities

The following sections provide step-by-step instructions, as well as an example, of how a general practice team can coordinate these activities to achieve effective clinical governance for quality and safety improvement purposes. The process should be led by a practice's clinical leaders with input from the entire practice team.

1. Creating a supportive organisational culture

An organisational culture that supports clinical governance is critical to continuous quality and safety improvement. This involves creating a practice environment that is open, inclusive, and encouraging of education, professional development, research, sharing good ideas and practices.¹

Such practices become learning organisations where constructive criticism, cooperative development and inter-professional respect allow successes to be celebrated, and where mistakes are treated as opportunities for improvement.⁶

1.1 Getting commitment from the top

The first step towards creating a supportive organisational culture is to ensure that practice owners and managers are clearly committed to making clinical governance a priority. To this end, they must provide evidence of their commitment. The following example of ABC Family Practice explains how.

Example: ABC Family Practice

Getting commitment from the top at ABC Family Practice began when several doctors attended an annual GP conference at which clinical governance and quality and safety improvement were major topics of discussion.

Having recently reviewed their patient population data, these doctors were aware of opportunities to improve the prevention and management of certain diseases.

In discussion among themselves, the GPs recognised that, despite individual doctors' best efforts, more could be done for their patients if their clinical efforts were supported by a practice-wide 'systems approach' to quality and safety improvement, focusing on:

Creating supportive practice culture

Appointing strong clinical leaders

GP Team (assignment of accountabilities)

Clinical audit

+

Risk management

+

Patient consultation

=

Quality and safety improvement

They relayed this to the practice principals, who were excited at the prospect of improving their practice's performance and the health of their patients.

In order to make clinical governance a reality, the practice principals:

- made it a strategic priority for the year
- authorised investment in the proposed clinical governance activities
- allocated the appropriate resources to their implementation.

1.2 Initiating culture change

Once clinical governance has become a strategic priority, the next step is to initiate culture change by communicating the vision and intended strategy to the entire practice team.

Example: ABC Family Practice

The practice principals realised all of their staff members needed to understand and share their vision for the practice to succeed. They sought the most appropriate way of communicating it in order to generate enthusiasm and support for their prime objectives.

Meetings were first held with clinical staff (doctors, nurses and other allied health professionals) during which presentations were given on the significance of clinical governance and its role in quality and safety improvement. Separate meetings (with less clinical detail) were held with non-clinical staff.

After conveying their vision, the practice principals reinforced their belief in the values underpinning successful clinical governance:

- transparency
- inclusiveness
- justice and fairness
- continuous learning
- constancy of purpose
- accounting for progress.

They next introduced the key systems and processes that would support the practice team in its efforts. This included new software for clinical audit and systems for risk management, including training, protocols and tools for:

- initiation of 'crucial conversations' with the treating team
- initiation of open-disclosure conversations with patients/carers
- incident investigation
- implementation of quality and safety improvements
- ongoing performance monitoring and reporting.



2. *Appointing strong clinical leaders*

Once a practice team embraces the concept of clinical governance and quality and safety improvement, it is critically important, in practices of any size, to identify leaders who will champion espoused values and effectively lead agreed clinical governance activities.⁶⁻⁸

Example: ABC Family Practice

After communicating their vision, values and strategy to the team, the practice principals sought to appoint strong clinical leaders who shared their vision and could enact espoused values and plans.

In trying to identify suitable candidates for the role, the practice principals reflected on the following:

Personal attributes

- passion for patient care
- professionalism and humanism
- ability to model good practice, challenge poor practice and inspire others
- enablers of change

Professional attributes

- credentials, clinical experience, level of authority
- diagnostic and therapeutic acumen

Setting directions

- contribution to service planning and resource allocation
- an understanding that clinical decision-making, and the systems that underpin it, are key determinants of quality and safety improvement

Working with others

- communication and interpersonal skills
- collaboration and task delegation with the ability to draw on the full capabilities of the practice team
- performance management
- professional accountability for the quality of:
 - their own work/performance
 - the practice team's work/performance

Improving services

- clinical audit capabilities
- risk assessment/management capabilities
- ability to identify opportunities for quality and safety improvement
- implementation of required changes, including system and process redesign

Commitment to quality and safety improvement and continuing professional development

- continuous involvement in quality and safety improvement and continuing professional development (CPD) activities
- encouragement of others to do the same
- acknowledgement of achievements
- clear demonstration of outcomes.

3. Assigning clear accountabilities

Clinical governance is based on the principle that 'all of us', clinical and non-clinical staff alike, are jointly responsible and accountable for the quality and safety of patient care.⁹

However, in general practice settings, where patient care involves multi-disciplinary teams with over-lapping roles and responsibilities, it can be difficult to precisely define who is accountable for what.

It is therefore imperative that accountability for maintaining high standards of care is clearly assigned to each member of the practice team and all staff members are engaged in the process.

Example: ABC Family Practice

Although the practice principals and clinical leaders had ultimate responsibility for driving clinical governance and quality and safety improvement, they understood its success required the efforts of the entire practice team.

They all agreed the best way to harness the team's potential was to increase everyone's sense of 'ownership' through individual assignment of clear roles, responsibilities and accountabilities.

Position descriptions

After carefully considering their clinical governance requirements, each member of the practice team was given a broad description of their clinical governance roles, responsibilities and accountabilities. These were documented in individual position descriptions and assigned according to each person's qualifications, skills, experience, scope of practice, level of authority and functional relationships.

Performance objectives

Individual and collective performance objectives were also set and communicated to the entire team through formal documentation and staff meetings.

Capacity development

Given all healthcare providers had CPD obligations, the clinical leaders sought to identify accredited quality and safety improvement CPD activities that would help each healthcare provider meet:

- their individual clinical governance performance objectives
- the practice's overall clinical governance objectives
- the CPD points requirement of their respective education providers.

Performance measurement

Team members were advised that their individual and collective performance, and progress towards achieving performance objectives, would be periodically reviewed, with individual or team responsibilities and accountabilities revised as needed.

4. Performance measurement

In one form or another, performance measurement has been part of good clinical practice for generations. Although initially regarded as a medical prerogative, in recent years performance measurement has come to include other members of practice teams, as well as patients.

4.1 Clinical audit

Clinical audit can be used to evaluate the effectiveness of a healthcare team's clinical practices in terms of the resulting service quality, treatment outcomes and patient experiences. It involves the measurement and comparison of clinical performance against agreed standards, with refinement of clinical practice to address identified opportunities for quality and safety improvement.

One way of initially approaching clinical audit for clinical governance purposes is to look at a patient population's demographics and the distribution of health risk factors and disease.

Note: The following figures present examples of ABC Family Practice's clinical audit results. They have been created using fictitious clinical software with patient data dashboard capabilities and advanced computer graphics.

The ability to present patient data in this way is often dependent on the correct entry of specific patient bio-metrics in specific fields in your clinical software. The current clinical software packages used in Australian general practices vary in their clinical audit and reporting capabilities, and may or may not be able to present patient data in this way.

This should not deter practices from using their existing clinical software for clinical audit purposes. Practices are encouraged to review their clinical software and data entry methods to ensure they make optimal use of their software for clinical audit and reporting purposes.

Example: ABC Family Practice

Having prepared the practice team for participation in well-defined clinical governance activities, the appointed clinical leaders sought to better understand the composition of their patient population, the associated health risk factors and patterns of disease.

They started by using the newly-installed clinical software (with patient data-dashboard capabilities) to visualise their patient population's:

- demographics, such as:
 - age
 - gender
 - cultural background
 - socioeconomic status.
- distribution of health risks, such as:
 - being overweight
 - smoking
 - excessive alcohol consumption
 - poor diet and physical inactivity.



Figure 2. Patient population demographics and health risk factors

The clinical software revealed a high proportion of the practice's patients were:

- middle-aged (45 years) or older
- of low–middle socioeconomic status (as indicated by prevalence of Commonwealth concession cards)
- overweight.

Patient population demographics and the distribution of health risk factors can help reveal the prevalence of certain diseases. Depending on a practice's initial findings, it can run more targeted clinical audits for diseases that are likely to be associated with a particular demographic or set of risk factors.

Example: ABC Family Practice

Given their preliminary results, it was suspected there would be a significant incidence of vascular disease among the practice's patients. The clinical leaders used their clinic software to further assess, and ultimately confirm, a high prevalence of ischemic heart disease.

This led the clinical leaders to question whether vascular risk factors were being adequately managed. A more focused audit of patients' diabetic, hypertensive and hyperlipidaemic (LDL-C) status, and their level of control, was performed.

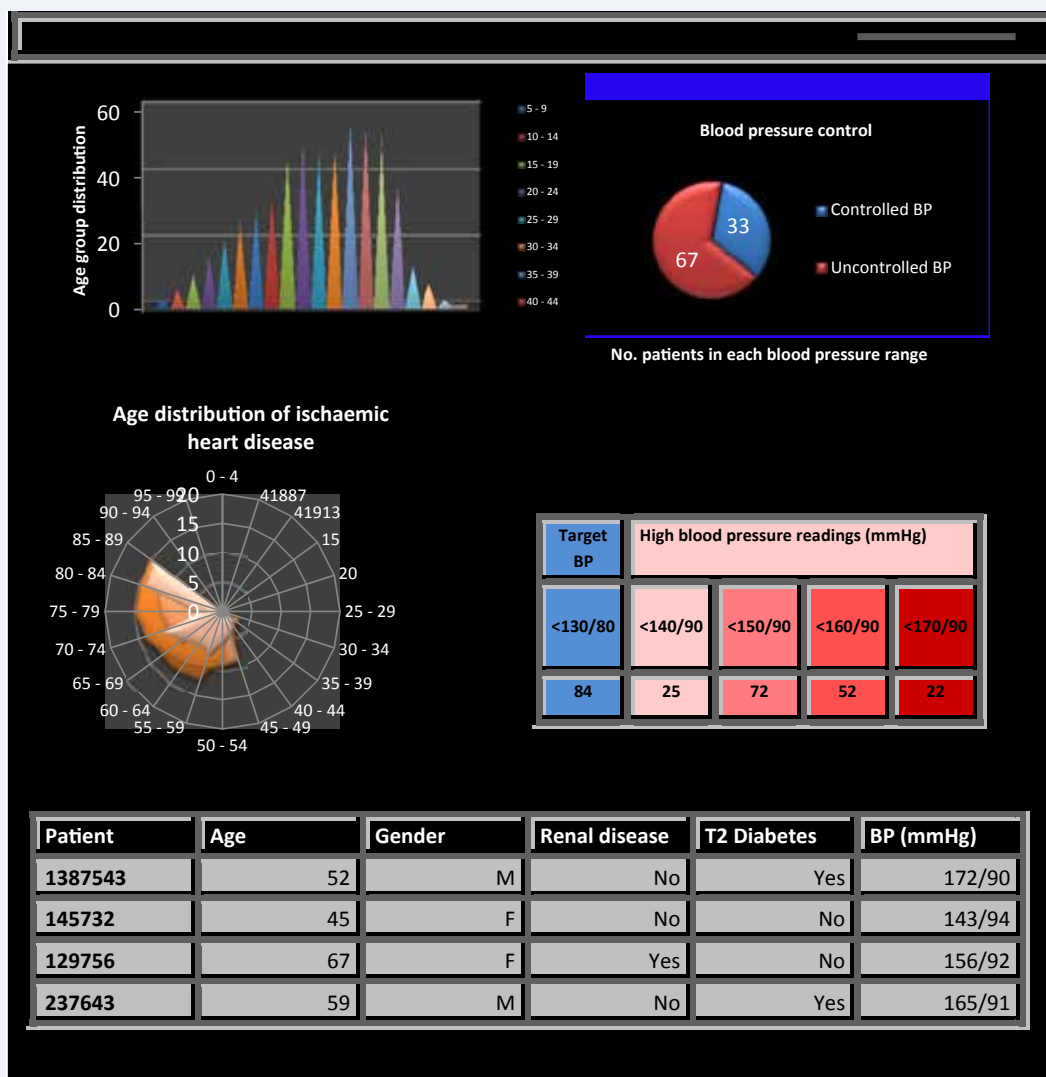


Figure 3. Prevalence of disease

Example: ABC Family Practice

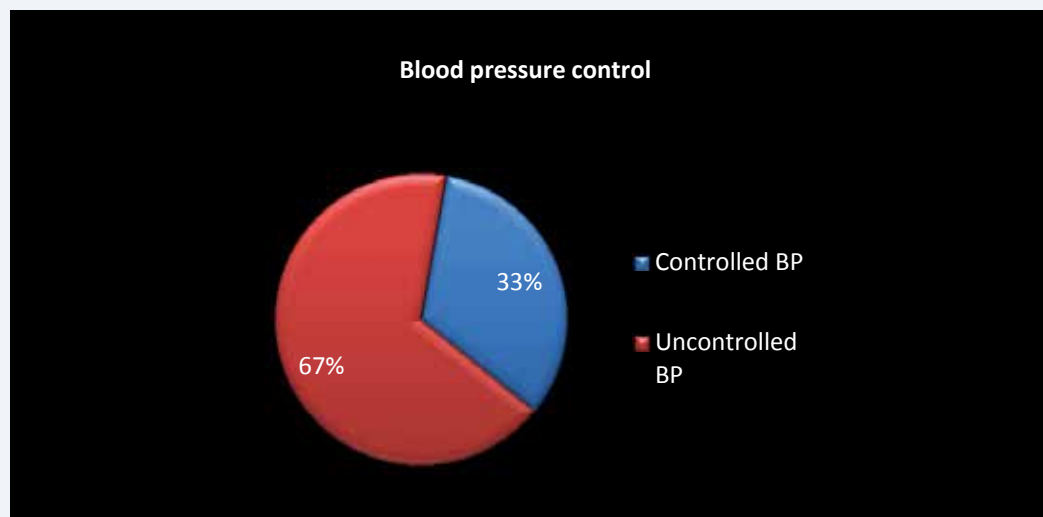


Figure 4. Controlled blood pressure

Closer inspection of the results revealed the percentage of hypertensive patients with controlled blood pressure (BP) was lower than the healthcare team's expectations. While the detection and treatment rates for hypertension were high, the control of blood pressure (to less than 140/90) was only 42%.

The practice team was concerned about this because it was understood that hypertension is the most important modifiable risk factor for:

- coronary heart disease (leading cause of death in Australia)
- stroke (third-leading cause of death in Australia)
- congestive heart failure
- end-stage renal disease.

Having identified a high prevalence of modifiable risk factors and/or specific disease states, a practice can review how those health risk factors or disease states are being treated and determine the resulting service quality, treatment outcomes and patient experiences.

Example: ABC Family Practice

Given the poor clinical outcomes observed during the initial clinical audit, and that hypertension is a leading modifiable risk factor for coronary artery disease, congestive heart failure, stroke and end-stage renal disease, the clinical leaders decided to evaluate the way the condition was being managed by themselves and their healthcare team.

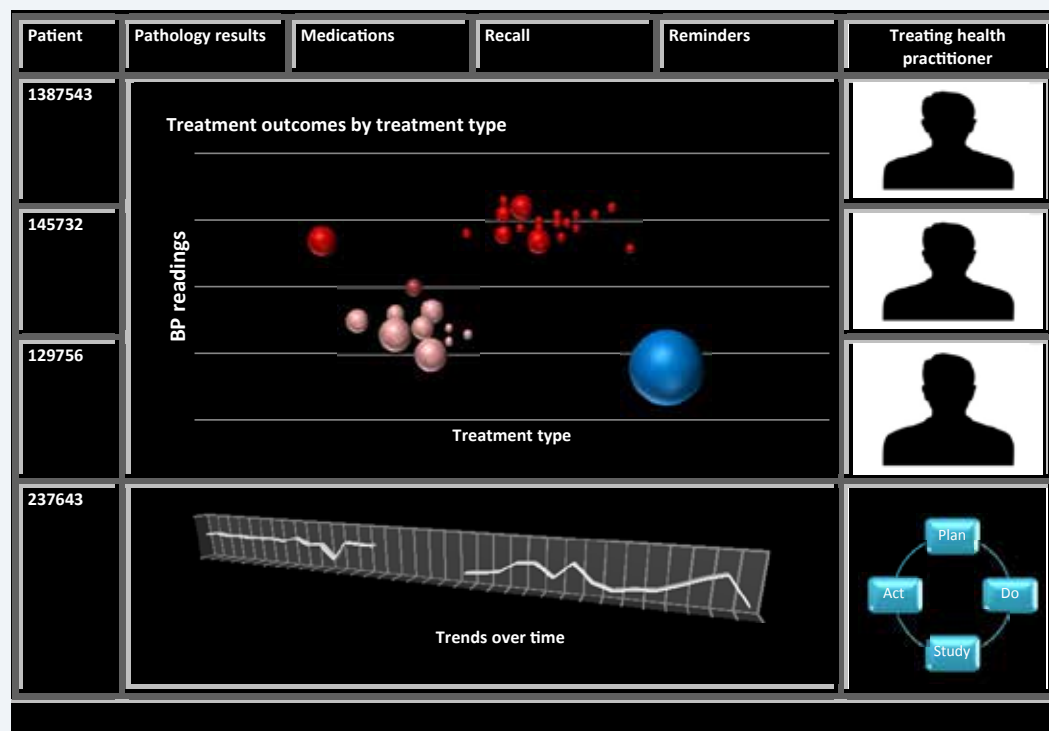


Figure 5. Clinical practices

A detailed audit of the healthcare team's clinical practices for patients with hypertension revealed the following information:

Clinical interventions	BP measurements were mainly taken by the doctors; BP was measured infrequently (average of once yearly) in patients with BP not controlled to target; 55% had medications for hypertension; only 32% had documented lifestyle counselling.
Service quality	67% of patients had seen more than three different doctors during the audit period.
Treatment outcomes	33% of patients had their BP controlled to less than 130/90; 9% were controlled to less than 140/90; the rate of adverse effects from all anti-hypertensive medications was low (4%).
Patient experiences	A supplementary patient survey revealed that common complaints included difficulty obtaining an appointment, being prescribed new medications, inadequate explanations during treatment and lack of non-medication options being given.

Once a practice has a clear understanding of the way it is treating a certain disease, it can compare this with identified examples of best practice from either within or outside its practice. This will help determine the gap from the ideal situation and reveal what can be done to improve service quality, treatment outcomes and patient experiences.

Example: ABC Family Practice

A comparison of ABC Family Practice's treatment outcomes to the Australian Heart Foundation's best practice treatment targets revealed:

- only 9% were treated to target BP of less than 140/90 with no cardiovascular disease (CVD)
- only 4% were treated to target BP of less than 130/80 with CVD, diabetes or proteinuria.

To increase the proportion of patients (with absolute CVD risk) treated to target BP, the Heart Foundation recommended that, as a minimum, there should be:

- measurement of absolute CVD risk in all hypertensive patients
- higher frequency of BP measurement where appropriate
- provision of lifestyle advice to all hypertensive patients
- consistent and appropriate follow-up appointments organised for patients who needed them.

4.2 Risk assessment

Looking at the frequency of patient safety risks or incidents (errors, near misses or adverse events) that occur during the course of service provision is another way of evaluating quality in healthcare. The findings will help inform selection of the most appropriate method of addressing the known causes – the choice of risk management strategy. Consider the following example:

Example: ABC Family Practice

The clinical leaders understood patient safety was a key dimension of quality. They decided to review their hypertensive patients' medical records in search of any safety risks or incidents associated with their treatment.

The practice was found to be involved in an incident in which one of the hypertensive patients had a missed myocardial infarction because a blood test result (elevated troponin) had not been reviewed.

The clinical leaders used a risk matrix (such as that shown below) to categorise and rank the incident according to the:

- likelihood of it re-occurring
- severity of the associated consequences.

With likelihood and consequences combined producing the level of risk.

	Consequences				
Likelihood	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
A (Almost certain)	H	H	E	E	E
B (Likely)	M	H	H	E	E
C (Possible)	L	M	H	E	E
D (Unlikely)	L	L	M	H	E
E (Rare)	L	L	M	H	H

L = Low risk, M= Moderate risk, H = High risk, E = Extreme risk

Figure 6. Risk matrix

As it was considered 'possible' for the incident in question to reoccur, and be of potentially 'catastrophic' consequence, it was ranked ahead of all other identified risks in the practice's clinical risk/incident register.

Given its high priority, the incident was immediately investigated by the practice team in order to identify the causes, as well as any opportunities for systems changes that would prevent similar lapses in patient safety from occurring in future.

The investigation process involved:

- reviewing the patient's record
- interviewing the treating practitioner and nurse in a supportive and non-judgemental manner
- interviewing the patient.

The broader 'systems' issue of how incoming test results were managed by the practice team was also analysed. During this investigation, staff members were encouraged to express their concerns and suggestions for system improvement.

Their investigation and analysis of the findings revealed shortcomings in the handling and management of incoming test results.

The team's ability to openly and confidently discuss patient safety incidents with their colleagues and the wider practice team in a supportive environment was also examined.

4.3 Patient consultation

Capturing patient feedback through routine consultation or formal patient surveys helps healthcare teams better understand their impact on the patient experience.

When designed and administered appropriately, patient-experience surveys can provide a robust measure of the quality of patient care. This involves assessing more than just 'patient satisfaction', which can be influenced by factors unrelated to a patient's healthcare.

Common measures of patient experiences include:

- access and availability
- information provision
- privacy and confidentiality (protection of)
- communication with clinical staff
- interpersonal skills of clinical staff
- continuity of care.

Example: ABC Family Practice

During clinical audit and risk assessment, it was decided the practice would increase patient engagement in service improvement through the use of patient-experience surveys.

The initial survey helped identify shortcomings such as difficulty obtaining an appointment and the lack of non-medication options given.

The survey also highlighted a variety of customer service issues such as the desire for patients to communicate with their GP via email, waiting times and the comfort of seating.

Like any business, a practice needs to continually monitor and improve its product and service delivery. The issues raised in patient-experience surveys constitute important feedback on customer service which a practice should evaluate, prioritise and take action on over time, as resources allow.

More information about developing and conducting patient surveys can be found in the RACGP's *Patient feedback guide: Learning from our patients*.

5. Quality and safety improvement

Quality and safety improvement is dependent on knowledge transfer. General practice teams can use what they learn about their patient populations (through clinical audit, risk assessment and patient consultation) for direct quality and safety improvement purposes.

One way of achieving this is through repetitive cycles of Plan, Do, Study, Act.

5.1 Plan

Planning starts with the development of a Specific, Measurable, Attainable, Relevant and Time-limited (SMART) Plan. A SMART Plan serves as a declaration of intent and typically sets out a practice's:

- identified opportunities for clinical improvement
- action plan to achieve the desired results
- clear measures of success.

Developing a SMART Plan also increases a practice team's awareness and control over what must be done – as well as when, how and by whom it should be done – to achieve the desired results. A SMART Plan can be developed by answering the following questions:

Specific

- Why is this issue a priority?
- What needs be accomplished?
- What specific actions need to be taken to achieve the desired results?
- Who should be responsible for implementing the SMART Plan?
- When should the proposed actions be taken?

Measurable

Can we track progress in terms of the SMART Plan's impact on our:

- clinical practices?
- service quality?
- patient outcomes?
- patient experiences?

Attainable

- What human and non-human resources are needed to implement the SMART Plan?
- Is it realistic to expect that the proposed actions will be accomplished with the available resources?

Relevant

- How will the proposed action items help achieve the desired results?

Time-limited

- How long will it take to accomplish each task?
- With what frequency should progress be monitored?
- Where should due dates and deadlines be set?

Below is an example of ABC Family Practice's SMART Plan for improvement of BP control among its hypertensive patients.

Example: ABC Family Practice – SMART Plan						
Why is this issue a priority?						
The ABC Family Practice team decided it needed a plan to improve BP management for its hypertensive patients given:						
<ul style="list-style-type: none"> • the identified poor treatment outcomes for their hypertensive patients • hypertension is a leading modifiable risk factor for coronary artery disease, congestive heart failure, stroke and end-stage renal disease. 						
What needs to be accomplished?						
Their stated aim was to improve BP control to:						
<ul style="list-style-type: none"> • target (less than 140/90) in those without CVD • less than 130/80 in those with diabetes, CVD or proteinuria. 						
Who is in charge of planning?						
The practice's clinical leaders were in charge of planning, with input from the entire practice team.						
What specific actions need to be taken to achieve the desired results?						
S	M		A	R	T	
Specific	Measurable		Attainable	Relevant	Time-limited	
<i>Action items</i>	<i>Responsibility</i>	<i>Indicators of success</i>	<i>Resource allocation</i>	<i>Why action is relevant to goals</i>	<i>Implementation date</i>	<i>Review date</i>
Educate healthcare providers within the practice	Dr 1	All nurses and doctors have attended an education meeting	Several scheduled meetings to cover different staff availabilities, attendance register, clinical guidelines (Australian Heart Foundation)	All doctors and nurses need to be aware of the practice's aims to improve hypertension control and BP treatment targets	TBA	TBA
Develop a register of patients with hypertension, highlighting those with uncontrolled BP	RN1	Complete and functional database that covers all practice patients	Extra paid data entry time, receptionists to direct patients with no recorded BP to have measurement by RN	Allows healthcare providers to focus treatment efforts, and for establishment of more detailed baseline to measure treatment outcomes against	TBA	TBA
Dr = Doctor, RN = Registered nurse, PN = Practice nurse						

S	M		A	R	T	
Specific	Measurable		Attainable	Relevant	Time-limited	
Action items	Responsibility	Indicators of success	Resource allocation	Why action is relevant to goals	Implementation date	Review date
Measure absolute CVD risk in all patients with hypertension	All doctors	Absolute CVD risk score documented in all records of patients with hypertension	Educate all doctors and RNs on measurement of absolute CVD risk, place Heart Foundation absolute CVD risk charts in all consulting rooms	Estimate overall CVD risk in order to further risk stratify patients with hypertension and to focus treatment efforts	TBA	TBA
Provide lifestyle management advice to all patients	All doctors and RNs	Provision of lifestyle counselling documented in all records of patients with hypertension	Printed brochures, referral pathways to dietitians, list of local health and fitness services (gyms, walking groups, weight-loss support groups, etc.)	Avoid/reduce pharmacotherapy – patients appreciate lifestyle advice	TBA	TBA
Provide consistent and appropriate follow-up	Doctors and reception staff	All patients with hypertension who attend have their next follow-up appointment pre-booked with their regular doctor	Doctors and/or receptionists trained to book next follow-up appointment. Automated patient reminder systems are linked to patient records	Patients prefer to attend their regular doctor, improves compliance, monitoring of treatment's effectiveness	TBA	TBA
Improve systems for the management of incoming test results	Doctors and reception staff	Processes for the management of incoming test results were changed and staff were educated about the changes	All doctors review and sign their patient results before they are filed	Reduces the risk of an abnormal result being filed without being acted on	TBA	TBA
Improve systems for patient engagement in disease prevention and management	Doctors and PNs	Prepare a GP Management Plan for all eligible patients with CVD	Arrange longer appointments for GPs and practice nurses to complete the plan with the patient	Patients have better understanding of the steps to be taken to achieve treatment goals	TBA	TBA

Dr = Doctor, RN = Registered nurse, PN = Practice nurse

5.2 Do

Once a practice has developed a SMART Plan, its time to 'do' what has been specified in the plan.

Example: ABC Family Practice

ABC Family Practice clinical leaders set out to implement their plan. They started by ensuring:

- the entire practice team understood the SMART Plan
- each team member had clear roles, responsibilities and accountabilities:
 - Dr 1, an associate doctor and medical educator, was given the responsibility of organising education on the practice's hypertension treatment targets and updates on hypertension diagnosis and management.
 - RN1 was given responsibility for developing a register of patients with hypertension, monitoring statistics on the proportion of hypertensive patients with a CVD risk measurement, and provision of lifestyle advice.
 - The practice manager was given responsibility for ensuring the availability of follow-up appointments for patients with hypertension.
- supporting clinical resources, systems and processes were in place:
 - Clinical standards and indicators against which to measure performance.
 - Clinical software to capture and analyse performance.

The clinical leaders participated in quality and safety improvement activities targeted at better BP control, encouraging others to do the same. Dr 1 organised a number of lunchtime meetings over the SMART Plan period around topics such as CVD, assessment of CVD risk and updates in hypertension management. A clinical staff member (usually a GP) or a guest specialist presented on a topic. Staff members were encouraged to bring their lunch in to the meeting. Attendance was recorded for CPD recognition.

They managed risk by:

- reinforcing the importance of patient safety
- reminding the team of recent incidents due to systems failure
- encouraging vigilance and willingness to act on perceived risks
- ensuring the team was familiar with and able to effectively use:
 - crucial conversation skills
 - open-disclosure policies and practices
 - risk/incident registers
 - incident investigation techniques
 - reporting templates
- reviewing and augmenting the team's ability to appropriately respond to risks/incidents.

Finally, they demonstrated clinical outcomes and acknowledged individual/team achievements.

5.3 Study

Once a SMART Plan has been implemented, the practice team needs to 'study' or evaluate the extent to which it achieved the intended results.

Measuring and reporting clinical performance and conformity to agreed clinical standards can be the first step towards understanding the extent to which a practice has achieved the desired results.

Example: ABC Family Practice

Conformity to standards

After 7 months of actively implementing the SMART Plan intended to improve BP control in the practice's hypertensive patients, final performance measures against each goal listed in the SMART Plan were recorded. This revealed:

- all staff members received education on the SMART Plan and most clinical staff members attended several clinical education meetings
- a register of patients was established. In addition, 63% of patients older than 45, with diabetes or CVD, who had no recorded BP, had their BP measured
- 84% of hypertensive patients had their absolute CVD risk score measured
- 81% of hypertensive patients were provided with lifestyle advice
- 91% of hypertensive patients were seen at least twice in the review period, a reflection on improved follow-up arrangements
- 62% of patients (with no CVD) were treated to target of less than 140/90 (up from 9% previously)
- 47% of patients (with diabetes or CVD) were treated to target of less than 130/80 (up from 4% previously).

The practice team also met regularly to discuss progress, problems and complaints encountered, as well as suggestions for improvement, throughout the SMART Plan's implementation. Team members would follow-up on actions agreed upon during the meeting (eg. arrange education on a specific topic, counsel particular staff members on performance, arrange further patient experience surveys, etc).

Education sessions for staff members also functioned as informal meetings during which performance was presented and problems and solutions discussed. In addition, bulletins were regularly posted in the staffroom, informing staff members about their collective progress.

Example: ABC Family Practice**Impact reports**

Following measurement of a SMART Plan's clinical impacts, the clinical leaders prepared a report on their findings. This included information relating to:

- all staff (clinical and non-clinical) performance audit results
- conformity to agreed clinical standards
- status of risk prevention and management strategies, including:
 - rate of error/near-miss/incident occurrence
 - recommendations for patient safety improvement
 - follow-up actions.
- patient feedback.

Performance review meetings

The impact report subsequently became the focal point of formal performance review meetings, scheduled and conducted by the leadership team at set intervals.

These meetings saw the performance of (individual and collective) clinical governance accountabilities reviewed for continuing suitability, adequacy and effectiveness.

This included review of:

- how the practice-wide clinical governance system was being led and directed
- how accountability was addressed
- how clinical decision making was supported
- whether there was evidence of integrated planning for quality and safety improvement
- whether steps were taken to strengthen the clinician's professional development and how this was aligned with their individual and the team's clinical governance objectives
- whether there was progress towards involving all multi-disciplinary clinical staff in clinical audit activities, with evidence of the effects on clinical care
- whether there is evidence of the practice actively working with patients/carers to achieve better patient outcomes
- whether there is evidence of how lessons are being learned and applied following adverse events, complaints and service reviews.

5.4 Act – on the results

The leadership team should visibly respond to the performance review results by:

- communicating the findings to all members of the practice team
- setting new goals and priorities for action in accordance with the findings
- assigning roles, responsibilities and accountabilities for action
- adequately resourcing the assigned clinical governance activities.

Example: ABC Family Practice

After studying the results the senior leadership team held a general lunchtime staff meeting (with lunch provided by the practice). A presentation reminded everyone about the reasons why the SMART Plan was implemented and the significance of the burden of CVD. The performance measures, before and after the plan's implementation, were then presented. The presentation also included ancillary effects such as improved patient satisfaction about the availability of appointments, positive feedback from guest speaker specialists and the number of CPD points gained from in-house education.

In recognition of the team effort, everyone was recognised for their efforts. Particular staff members, including Dr 1 (organising the educational program), RN1 (monitoring performance) and a 'most improved' practitioner, were singled out for recognition.

In light of the generally agreed upon success of the hypertension SMART Plan, and the positive effects it had on team morale and unity, the practice principals announced the practice would attempt a more ambitious quality and safety improvement SMART Plan – targeting type 2 diabetes – the following year.

In the meantime, the systems (hypertensive patient register) and routine clinical practices (measuring CVD risk and offering lifestyle advice) that had developed would be relied upon to continue delivering effective hypertension management, even though the active aspects of the SMART Plan (eg. regular education sessions) would be discontinued.

6. Resources

- A Quality general practice of the future
www.racgp.org.au/futuregeneralpractice
- A Quality framework for Australian general practice
www.racgp.org.au/qualityframework
- RACGP Standards for General Practices (4th Edition)
www.racgp.org.au/standards/contents
- RACGP Risk management in general practice – a guide and educational resource for individual and group based learning
www.racgp.org.au/your-practice/business/tools/safetyprivacy/clinical-risk-management
- RACGP Patient Feedback Guide: Learning from our patients
www.racgp.org.au/your-practice/standards/resources/patient-feedback
- RACGP General Practice Management Toolkit
www.racgp.org.au/publications/tools#2
- RACGP Rebirth of a Clinic – a design guide for architecture in general practice
www.racgp.org.au/rebirthofaclinic
- The RACGP infection control standards
www.racgp.org.au/infectioncontrol
- General Practice – a safe place
www.racgp.org.au/gpsafeplace
- The RACGP computer and information security standards
www.racgp.org.au/ehealth/security
- The RACGP implementation guidelines for video consultations in general practice
www.racgp.org.au/telehealth
- The Australian Commission on Safety and Quality in Health Care (ACSQHC) www.safetyandquality.gov.au
- National Health and Medical Research Council (guidelines)
www.nhmrc.gov.au/guidelines
- National Health and Medical Research Council (grants)
www.nhmrc.gov.au/grants
- RACGP Handbook for the management of health information in general practice
www.racgp.org.au/your-practice/e-health/protecting-information/privacy

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