Queensland Clinical Senate

Connecting clinicians to improve care

Clinical Education and Training

24 and 25 October 2013

Final report

Royal on the Park, Brisbane, Queensland

Queensland Clinical Senate (QCS) meeting 24-25 October 2013

Executive summary

Healthcare is now delivered in an environment of performance measurement. The purpose of the 12th meeting of the QCS was for participants to consider how key performance indicators (KPIs) for clinical education and training (CET) might stimulate investment and improvements in these areas and enable benchmarking between institutions. Participants were challenged to articulate those measures of quality in clinical education and training which KPIs should capture and develop a set of principles / framework for CET KPIs.

QCS recommendations

Performance Measures for Clinical Education and Training

The QCS recommends that effective measures of CET for Hospital and Health Services (HHSs) are developed to enable recognition of the important contribution of CET to the overall quality of the health system.

The QCS will take a leadership role by establishing a working group, in collaboration with relevant stakeholders from the education and training sectors, to provide a framework for the Department of Health to incorporate into Service Level Agreements with HHSs.

The QCS will:

- articulate the reason for developing performance measures as part of HHS service agreements
- identify specific performance measures in collaboration with
- outline the reporting process for the framework
- describe mechanisms to communicate outcomes
- explore opportunities for integration with existing national benchmarking frameworks.

Clinician Engagement (CE)

The QCS membership endorsed the QCS CE survey tool. This tool will be distributed to all HHSs and made available to Medicare Locals.

Advance Care Planning (ACP)

The QCS has identified ACP resources for use across Queensland to guide and document ACP discussions. The QCS recommends the resources are evaluated with the objective of statewide implementation in July 2014.

Dr David Rosengren
Chair
Queensland Clinical Senate
4 December 2013

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Presenters and Panellists

- Hon. Lawrence Springborg MP, Minister for Health
- Dr David Alcorn, Chair, Postgraduate Medical Council of Queensland
- Professor Alan Cripps, Pro Vice Chancellor, Health, Griffith University
- Professor Claire Jackson, Authority Member, National Health Performance Authority
- Dr John Kastrissios, General Practitioner, Board Director of the Australian Medicare Local Alliance
- Professor Sabina Knight, Director, Mt Isa Centre for Rural and Remote Health
- Dr Will Milford, Doctor-in-Training, General Obstetrics and Gynaecology
- Dr Susan O'Dwyer, Executive Director Medical Services, Princes Alexandra Hospital
- Dr David Rosengren, Chair, Queensland Clinical Senate
- Dr Jeff Rowland, Chair, Queensland Clinical Senate Advance Care Planning Working Party
- A/Professor Tony Russell, Chair, Statewide Clinical Network Chairs
- Dr Andrew Singer, Senior Medical Advisor, Department of Health and Ageing
- Professor Ged Williams, School of Nursing and Midwifery, Griffith University

1. Overview

The QCS meeting was attended by 120 people over 1.5 days. Guests included the Minister for Health, the Assistant Minister for Health, the Director-General, Department of Health Executive, Commissioner of Queensland Ambulance Service, Hospital and Health Board Chairs, Hospital and Health Service Chief Executives, and representatives from universities, professional colleges, the Commonwealth Department of Health and Ageing, the National Lead Clinicians Group, the National Health Performance Authority and other professional bodies.

Prior to the meeting, participants were invited to participate in a clinician engagement survey and a clinical education and training survey to inform discussion at the meeting.

2. QCS activity May – October 2013

Participants were provided with an update on activity following the May 2013. Key achievements included:

- Clinician Engagement (CE):
  - Development of a QCS position statement on effective CE
  - Development of a survey tool which aligns with the position statement on effective CE (attachment 1). The QCS membership provided strong support for the survey as a valuable tool to assist organisations measure CE
  - ➢ The survey will be distributed to Hospital and Health Services and Medicare Locals.
- Advance Care Planning (ACP):
  - Development of an ACP form and resources for use across Queensland. The QCS will recommend these resources be evaluated at several sites early 2014 prior to a rapid statewide implementation mid-2014 (attachment 2)
  - A joint meeting of the QCS and Commonwealth National Clinicians Network to identify components of a National Lead Clinicians Group plan for action on ACP
  - ➢ The QCS will draft a proposal to evaluate the ACP resources and recommend to the Department of Health that they be evaluated in 2014 with a view to a rapid statewide implementation.
- Disinvestment/Reinvestment:
  - QCS membership on the Health Policy Advisory Committee on Technology (HealthPACT) and Queensland Policy and Advisory Committee on Technology (QPACT)
  - Discussion with the Queensland Department of Health to progress the Statewide Radiology Strategy.

3. Opening address – Hon. Lawrence Springborg MP, Minister for Health

The Minister for Health thanked members for their ongoing commitment to improving the delivery of healthcare to Queenslanders through their role on the QCS. Having congratulated the QCS on its recommendations and activity following the May QCS meeting, the Minister reiterated his strong support for, and commitment to, the timely progression of the QCS recommendations for ACP and clinician engagement.

The Minister acknowledged the importance of clinical education and training to the delivery of high quality patient care and welcomed the QCS's input into the development of a framework and tools that will add value and assist in determining the effectiveness of programs and identifying areas requiring improvement.

4. Clinical Education and Training (CET)

Meeting objectives

Education and training are critical elements in a contemporary health service. Effective educational strategies improve patient safety and health service performance, as well as support development of the future healthcare workforce.

Healthcare delivery now operates in an environment of performance measurement. Under the auspices of the National Health Performance Authority (NHPA), health services are required to report performance in a range of clinical indicators. This has directly influenced performance in many cases and allows (publically available) benchmarking between institutions.

Practical, evidence-based key performance indicators (KPIs) for education and training which link to key clinical, patient and workforce outcomes may enable similar investments and improvements in these areas, and allow useful benchmarking between institutions.

QCS meeting objectives included:

- Articulate measures of quality in CET which KPIs should reflect i.e. *What* do we hope to achieve by developing KPIs
- Develop a set of principles/ framework for KPIs along with example KPIs that are valid, feasible to collect, relevant across professions and health service contexts, and able to be integrated into existing systems
- Plan next steps.

Panel hypothetical – summary of key points

Dr David Alcorn, Chair, Postgraduate Medical Council of Queensland

Professor Alan Cripps, Pro Vice Chancellor, Health, Griffith University

Professor Sabina Knight, Director, Mt Isa Centre for Rural & Remote Health

Dr Will Milford, Doctor-in-Training, General Obstetrics and Gynaecology

Dr Susan O'Dwyer, Executive Director, Medical Services, Princes Alexandra Hospital

Professor Ged Williams, School of Nursing and Midwifery, Griffith University

A/Professor Victoria Brazil, QCS meeting facilitator

Panellists participated in a hypothetical which explored the current status, perceived value in, and challenges of measuring CET in both the education and health service sectors. Key messages included:

- Research and workforce planning are key components of CET

- All stakeholders (e.g. clinicians, health services, education providers, accreditation bodies) must have early involvement in the development of KPIs if quality outcomes in education are to be achieved
- KPIs should measure the effectiveness of CET across the continuum (i.e. university education through to the training provided by the health sector)
- Student experience is important
- CET KPIs should have a relationship with patient outcomes (education in safety and quality and education in teams for good patient outcomes) and community need. Outcome and process measures are required to achieve this
- Perceived value in identifying distinct funding mechanism/s for teaching provided by clinicians in the health sector (vs. provision of clinical care)
- The importance of addressing macro/system level issues (e.g. workforce planning, activity) to drive cost effectiveness
- Other considerations for success: input from learners (in the creation, governance and surveillance of measures); systems to collect the data for KPIs (data collection cannot create additional burden); engagement with staff who are responsible for producing the outcomes against the KPIs
- Innovative thinking is needed to tackle complex problems and challenges.

Summary of participant responses to CET pre-meeting survey

Participants were invited to participate in a survey prior to the meeting to inform discussion. Themes from the feedback included:

- 95% agree/strongly agree that "…valid, reliable and feasible KPIs for education and training in health services can be developed"
- 78% agree/strongly agree that "formal health service KPIs for CET will enhance the quality of education"
- 76% agree/strongly agree that "formal health service KPIs for education will enhance the quality of patient care". 24% were uncertain.
- KPIs should link as directly as possible to existing KPIs for clinical service outcomes
- Framework principles: need to be realistic, relevant and measureable; cover volume (output) and quality; be broadly applicable across professions and specialties; be linked to quality of care and patient safety; must be easy to collate; be immune to 'gaming'; able to be flexible and contextualized.
- KPIs might include:

- "% of clinicians engaged in training, % of training directly related to patient care, % of training from impartial sources, training involving more than profession type so as to encourage improved cohesion"
- "..Linkages between patient outcome data and education provided - e.g. Use of error data to inform education. Types of education provided. Team and inter-professional training opportunities"
- "Staff Retention, Staff Satisfaction, Measures of Best practice in Health Outcomes, Workforce measures (e.g. District Workforce Shortage), Graduate employment statistics."

- Perceived risks:
  - "You get what you measure - only."
  - "That they become a box to tick, and are in fact not actually an indication of performance, or have any impact upon training or patient outcomes…"

Summary of key points from presentations by invited guests

Professor Alan Cripps, Pro Vice Chancellor, Health, Griffith University

- KPIs identify and measure behaviours against strategic aspirations, encourage high quality training, education and research, enable a fair and efficient system to determine research and training outcomes
- The aim of KPIs is to measure the quality of performance (reliable data, cost effective, links to funding, adaptable, applicable to various clinical environments)
- Learning and teaching KPIs at Griffith University include a focus on local (e.g. retention, student experience, domestic coursework enrolments) and national measures (e.g. CEQ overall satisfaction index, CEQ good teaching scale, graduate success). Research KPI focus on: research income, publications (output and quality), intensity and training
- What works: KPIs that drive aspirational behaviour, accurate data, top down plus bottom up consultation (culture), staff profiling to achieve KPI outcomes, long-term investment
- What doesn't work: inaccurate/inaccessible/costly data, frequent/onerous/complex reporting, rewards that drive bad behaviour (gaming), poor consultation with disciplines/environments (top down)
- Focus on resources that support enablers and discourage the barriers to effective CET (e.g. time, ongoing funding, human resources and culture).

> "While compliance KPIs for CET are important, aspirational KPIs will deliver improved outcomes and efficiencies"
> *Alan Cripps*

Professor Claire Jackson, General Practitioner and Authority Member - National Health Performance Authority

- National Health Performance Authority Mission: to monitor, and report on, the comparable performance of health care organisations to stimulate and inform improvement in the Australian health system, increase transparency and accountability and inform consumers
- What works to accelerate improvements in care – international lessons to be learnt:
    - Locally relevant information about healthcare organisations
    - Comparable performance information in relation to peers and after accounting for differences between organisations in patients
    - Nationally consistent
    - Impartial and transparent
    - Engagement: review the data to benchmark with peer groups
- Public reporting can act as a catalyst for change e.g. legislative changes to amend the *Public Health Act* in New South Wales following the Healthy Communities: Immunisation rates for children in 2011–12 Report.
- NHPA indicators don't directly measure CET performance. State and Commonwealth Ministers' support will be required to change this.
- Importance of linking community based outcomes with hospital service outcomes

> *"Less is more – indicators should be limited in number, be relevant locally, easy to collect, reliable, and meaningful to quality improvements"*
> *Claire Jackson*

Dr John Kastrissios, General Practitioner, Board Director of the Australian Medicare Local Alliance

- Quality improvement thinking/systems/processes are not consistently and deeply embedded in the culture of general practice despite it being present for some time. Measuring can be seen as a process removed from daily practice by coalface clinicians - resistance is common
- Patient experience, while difficult to measure, is important
- Chronic disease, mental health and cancer care are services where primary care and health services work together to improve patient outcomes. Collaboration to develop CET measures for processes and outcomes is occurring
- General Practice environment is well suited for inter-professional and multi-level learning
- KPIs and outcome measures which focus on transfer of care and multidisciplinary CET would be valuable as would linking integrated KPIs to General Practice accreditation

- Goals for KPI development might focus on: interdisciplinary CET (e.g. around chronic disease services, NHPA standards, access to services) and education that redefines practitioners' professionalism and accountability to the patients in their care)

> "Funding, clinical leadership and collaboration across the system is vital"
>
> *John Kastrissios*

Dr Andrew Singer, Senior Medical Advisor, Department of Health and Ageing

- Understanding what the goal is e.g. quality (outcomes, outputs and processes) and performance benchmarks
- Data for measurement must be accessible
- Developing a framework is important to delineate the areas worth measuring and connecting them
- Candidate frameworks: the Performance and Accountability Framework (NHPA); Australian Medical Council Accreditation Standards (Specialist Training); General Medical Council Quality Improvement Framework - Governance
- In terms of CET measurement, there appears to be little work done to date which focuses on outcomes
- Current measures are mainly process measures (inputs) and include but are not limited to: Medical Training Review Panel Annual Reports, Medical Schools Outcomes Database (MSOD), Health Workforce Australia, Australian Health Practitioners Regulation Agency Medical Workforce Survey
- Risks to measuring CET:
    - assessment drives learning, targets and indicators drive behaviour
    - the need to balance priorities (the primary aim is to care for patients, but clinical care suffers without quality education and training)
    - the selection criteria used for indicators - must be relevant, valid, reliable, attributable, simple and cost effective
- Both education and service are important - sometimes both are happening at the same time
- Integration with existing processes and measurements is important
- CET is an investment made by everyone.

> *"It is important that there is some funding that is explicitly tied to education and training""*
>
> *Andrew Singer*

Measures of quality in CET which KPIs should reflect

Participants were asked to articulate what is hoped to be achieved by developing KPIs for CET from a health service perspective. Feedback on key outcomes that might indicate high quality CET in a health service included:

- High quality care (improved clinical outcomes, patient care and patient experience)
- High culture and morale with strong clinical leadership
- High productivity and efficiency
- Improved workforce planning, staff retention and recruitment
- Consistency of clinical practice and compliance with best practice
- Improved / increased inter-professional/team-based education and training
- Better quality teachers and teaching
- Enhanced learner experience
- Enhanced and supported accreditation processes
- Make connections / gain overview of data already collected
- Better support for CET's 'slice' of resources
- Better collaboration with educational providers across the system/sectors.

A framework/principles for KPIs

Participants were asked to describe the characteristics of effective CET in a health service. Key themes included:

- Patient and quality outcome focused
- Aspirational and compliance focused
- Valid
- Measurable
- Reliable and reproducible
- Locally relevant
- Applicable across professions and regions
- Made in collaboration with education and training partners/sectors
- Linked with ongoing CET and workforce planning

Candidate KPIs that could be incorporated into health service reporting

Participants were asked to identify priority outcomes and candidate KPIs for further consideration:

Mechanism/Outcome (?)	Measure/KPI
Positive student teacher patient institutional learning experience (Education consumer index … a survey of the subjects of education)	• benchmarked 'education consumer index' – a survey of the subjects of education where result encompasses the student, teacher, and patients • satisfaction scores/absenteeism
Adequately resourced CET programme	% of total budget allocated to CET
High quality / adequately trained teachers	• % of staff appropriately credentialed teachers to provide training • % of senior staff with 'formal' training in teaching (i.e. participated in teaching professional development e.g. teaching on the run as opposed to tertiary qualifications in teaching) • Rates of retention of high quality teachers
Adequate time for teaching and learning	% of protected time allocated to teaching and study
Safe care provided by trainees	Root cause analysis of trainee error
Interdisciplinary institutional training/development/learning plan in place (in collaboration with education and training partners) for undergraduate and postgraduate training	• Existence of plan and governance structure to support the plan • % of education expenditure allocated/total service expenditure
CET Culture (including the need for the innovation)	• % of staff that have an individualised development plan in place • % of budget spent on CET, including investment in formal CET appointments, physical and IT infrastructure
Effective interdisciplinary communication	% of patient complaints related to poor communication
Continuing professional development compliance with colleges and health services	Benchmarked compliance of CPD within the timeframes of the respective bodies

Skilled and engaged workforce	• Benchmarked staff retention rates • % of students as % of workforce in that field • % of educational opportunities for the workforce that are provided by 'accredited professional bodies' • Increased number of indigenous health professionals
Governance structures in place (to set structures and processes) to ensure CET is linked to quality care and safety	Evidence within annual board reports of a commitment to CET for all staff (e.g. cleaners -> executive)
Improved patient outcomes through continual quality improvement	All staff working to an agreed scope of practice within appropriate skills training (i.e staff are fit for purpose)
Improved collaboration and integration with educational providers and standards regulators	• Evidence of implemented effective quality systems in place (e.g. performance appraisals) • Evidence of improved teamwork and inter-professional education
Minimum standard for education, training and research per department	% time and resources devoted to education and training
Minimum curriculum for ongoing professional development for all professions	Benchmarked positive impact on organisational impacts (e.g. research)
Research	Quantity and quality submitted and published

5. Next steps/closing remarks

Dr David Rosengren, Chair Queensland Clinical Senate

QCS members supported the development of CET KPIs in consultation with all relevant stakeholders. It was agreed that KPIs would focus on input, governance and output measures.

Input	% of total budget allocated to CET
	% time and resources (human and other) devoted to education and training
Process	Governance KPI
	Governance with multi-professionals
	Simulation with multi-professionals
Output	Learner/student/teacher/patient institutional learning experience
	Staff retention

Dr Rosengren acknowledged that while the final product may not be perfect, and it may not cover every permutation, it would be a good and necessary start. Initially the QCS will focus on areas where it has most influence – the development of multidisciplinary (medical, nursing and allied health) KPIs for health services.

Having thanked members and guests for participating, Dr Rosengren invited attendees to register their interest in participating in a working group to progress the development of CET KPIs.

The next meeting of the QCS has been tentatively scheduled for 27-28 March 2014. Topics for QCS deliberations in 2014 can be forwarded to the QCS secretariat: gldclinicalsenate@health.qld.gov.au.

Attachment 1: Clinician Engagement

QCS Working Party Members:

Dr Tony Russell (CHAIR & QCS Lead)	QCS Executive member, Chair – Statewide Diabetes Clinical Network
Ms Brooke Cowie	Senior Acute Speech Pathologist, Metro North Hospital & Health Service
Ms Lesley Dwyer	Chief Executive, West Moreton Hospital and Health Service
Ms Kerrie Frakes	QCS Executive member, Director, Clinical Support Services, Central Queensland HHS
Ms Frances Harlow	Director of Nursing, Blackall Hospital
Ms Mish Hill	Director of Nursing and Midwifery Services, Adults, Women's & Children's Health Services, Mater Health Services
Ms Lorelle Marco	Nurse Educator Critical Care, West Moreton HHS
Dr Darren Neillie	Clinical Director, High Security Inpatient Service, The Park - Centre for Mental Health, West Moreton HHS
Mr John Woodward	Pharmacist, Board member Sunshine Coast Medicare Local

Working party guests:

Ms Tess Bradley	Clinician Planning & Leadership Unit, Health Systems Innovation Branch
Ms Paula Brown	Clinician Planning & Leadership Unit, Health Systems Innovation Branch

Draft Clinician Engagement Survey Questions:

1. What age are you?
2. What gender are you?
3. What is the principal organisation that you work for?
4. What is your profession?
5. How many years have you worked for this organisation?

Using a likert scale: *strongly agree/ agree/neutral/disagree/strongly disagree*

6. I am aware that my HHS/Medicare Local has a strategy for clinician engagement
7. My HHS/Medicare Local has been actively engaging and consulting with clinicians
8. My HHS/Medicare Local involves clinicians in the decision-making process around the planning, design and delivery of health services more than it did 12 months ago
9. I am involved in decision making which affects me and my work area
10. I believe that the decisions made by the HHS/Medicare Local are appropriate for benefiting patient care
11. My HHS/Medicare Local provides me with relevant data and protected time (if relevant) to evaluate and improve work practices
12. Communication between my HHS/Medicare Local management and me is sufficient, open and transparent
13. I am interested in leadership and/or management opportunities in this HHS/Medicare Local.
14. My HHS/Medicare Local really inspires me to perform at my very best in my job
15. I would recommend the services or care provided by this HHS/Medicare Local to a friend or relative
16. Could you suggest at least one initiative to improve clinician involvement and engagement in your HHS/Medicare Local?

Attachment 2: Advance Care Planning

QCS Working Party Members

Dr Kana Appadurai	Co-Chair, Statewide Dementia Clinical Network
Dr Ellen Burkett	Emergency Department Physician, Royal Brisbane & Women's Hospital
Ms Liz Crowe	Advanced Clinician Social Worker, Mater Hospitals, Brisbane
Ms Athena Ermides	General Manager, Berlasco Court Caring Centre
Dr John Flynn	General Practitioner, Brisbane
Ms Rosie Laidlaw	Advance Care Planning Consultant
Ms Sandra Glaister	Residential aged care service Manager, Leading Aged Services Australia Queensland
Dr Paul Neeskens	General Practitioner, Bayswater Family Practice. Wide Bay Medicare Local
Dr Liz Reymond	Director, Palliative Care Service, Metro South Hospital & Health Service
Dr Jeff Rowland (CHAIR)	Co-Chair Statewide General Medicine Clinical Network
Mr Mark Tucker-Evans	QCS Executive member, CEO Council on the Aging Queensland
Dr Paul Varghese	Chair, Statewide Older Persons' Health Clinical Network
Dr Rohan Vora	Chair, Statewide General Medicine Clinical Network–Palliative Care Sub-Network
Ms Sally Wecker	Consumer advocate
Prof Ben White	Director, Health Law Research Centre, QUT
Elizabeth Whiting (QCS Lead)	Co-Chair, Statewide General Medicine Clinical Network