

Final Report for RACGP ERG2023-08

**Supporting best practice in the GP Clinical Learning Environment:
a benchmarking and quality improvement tool**

Chief Investigator: A/Prof Samia Toukhsati, GPSA

Co-investigators:

Dr Tina George, GPSA

Ms Leila Greenfield, GPSA

Dr Simon Morgan, GPSA

A/Prof Rebecca Kippen, Monash University

Dr Kay Flynn, Christies Beach Medical Centre

A/Prof Belinda O'Sullivan, University of
Queensland

Ms Carla Taylor, GPSA

Ms Leonie Chamberlain, GPSA

Dr Charlotte Denniston, University of
Melbourne

A/Prof Kevin Arlett, James Cook University

A/Prof Jillian Benson, University of Adelaide

Prof Janice Bell, WAGPET

Dr Justin Coleman, GPSA

Dr Simon Hay, RACGP

Dr Lisa Clarke, RACGP

Dr Kerrie Stewart, RACGP

Dr Jenna Lyttle, Deakin University

Mr Oliver Little, Monash University

Ms Jo-anne Chapman, GPRA

Dr Srishti Dutta, GPSA

Introduction

High quality clinical learning environments are the cornerstone of excellence in general practice vocational training. In 2019, General Practice Supervision Australia (GPSA) led the development of a consensus-based Framework for the GP Clinical Learning Environment (GPCLE) setting out six elements describing excellence in the clinical learning environment. However, guidance to support real-world benchmarking and quality improvement in the GPCLE was lacking.

Aim and objectives

To develop and validate a benchmarking and quality improvement tool, adapted from the national GPCLE Framework, to support best practice in GP training. The objectives were to explore how and by whom the quality of the GPCLE elements should be measured, distinguishing levels of performance from foundational to exemplary, and what resources could support implementation.

Method

The methods involved co-design with a wide range of key stakeholders involved in GP training, including GPs, GP supervisors, GP trainees/new fellows and medical students, IMGs, Practice managers, RACGP Regional Directors of Training, GP training providers, GP training researchers, and medical educators. Data was collected over three stages:

1) *Scoping review, pre-workshop activity, and workshop to develop a draft GPCLE tool.*

Beginning in June 2023, the research team mapped the six GPCLE elements to the RACGP accreditation standards to minimise duplication of quality indicators in the GPCLE tool. In August 2023, the research team, Working Group, Steering Group and Expert Advisory Group were invited to complete a pre-workshop reflection activity to garner perspectives about how the GPCLE elements could be measured

objectively (such as behaviours or actions that demonstrate a commitment to quality). These results were collated by the research team and Working Group and used to inform the Workshop activities. In September 2023, a face-to-face workshop was held in Melbourne, facilitated by the research team and attended by the Expert Advisory Group. Workshop attendees were asked to quantify each GPCLE Framework element using objective quality indicators. After reviewing the indicators, small groups were asked to organise them into themes and arrange them on a performance continuum (from satisfactory to exemplary) to produce draft GPCLE items. Draft GPCLE items were then reviewed and refined via large group facilitated discussion. The research team collated and refined the draft GPCLE items. In October 2023, the GPCLE tool V1 was circulated as an online survey to the Expert Advisory Group for comment; the findings from which informed the GPCLE tool V2. In December 2023, the GPCLE tool V2 was circulated for a further round of expert review within the research team (research team, Working Group, Steering Group and Expert Advisory Group) and invited key stakeholders (eg., ACRRM, AMA, AIDA, RADAA, IGPRN, RVTS, RACGP SLOs); the findings from which informed the GPCLE tool V3.

2) *Online sector-wide survey.*

In February 2024, the online GPCLE tool V3 was disseminated via GPSA for sector-wide review to all those involved in GP training. Data collection concluded in early March 2024.

3) *Pilot test.*

An EOI to participate in the pilot study was included in the online sector-wide survey. Participation required a practice liaison person (eg., PM) to invite all staff within the practice, as well as current/recent registrars, to complete the GPCLE tool V3 online prior to a site visit. The site-visit comprised a one-day, face-to-face practice by two members of the research team (ie., the PI and a GP/ME), involving objective assessment of the practice and interviews with staff/learners. Practice staff/registrar quantitative self-evaluation data was compared to the objective (blind) site evaluation to assess the validity of self-assessment. Qualitative interview data was used to inform revisions of the GPCLE tool. Resources were identified to support implementation.

Results

Phase 1: Pre-workshop activity.

A total of 16 of 22 participants responded (72%). Responses were thematically analysed in NVivo and aligned with the original GPCLE Framework elements. Objective indicators of quality were categorised into themes and arranged across a performance continuum (satisfactory, to commendable, to exemplary), providing a scaffold on which to develop the GPCLE tool.

Phase 1: Workshop.

A total of 16 members of the Expert Advisory Group participated. A large volume of objective, quality indicators were developed for each GPCLE element (>250 in total), however, these required refinement. Post-workshop refinement by the research team generated the GPCLE tool V1.

Phase 1: 1st post-workshop review: Expert Advisory Group (EAG).

Nine of 21 EAG members responded, all of whom considered the tool valuable (ie., relevant/compatible) with GP training and 71% considered it feasible to implement in general practice. The nomenclature of the GPCLE tool was revised to improve clarity. The feedback resulted in refinement to reduce duplication and shorten the tool (GPCLE tool V2).

Phase 1: 2nd post-workshop review: Research Team and key stakeholders.

Eleven of 20 research team members and 2 of 10 key stakeholders responded, all of whom indicated that the items and indicators were valuable, relevant, and feasible to implement in general practice. All noted the tool as being appropriate to use annually or more often by practice managers, GPs, practice owners, learners and training entities. The feedback resulted in refinement to reduce duplication and shorten the tool (GPCLE tool V3).

Phase 2: Sector-wide review.

A total of 230 respondents began the survey, of whom a total of 188 answered at least one GPCLE tool item. There was good representation across all Australian states and territories and practice roles (including GP/RG supervisors, GP/RG registrars or new fellows, Medical educators, practice managers and others). Data analysis indicated that the standards were generally represented along a sequential quality continuum and that future iterations of the GPCLE tool should: require respondents to evaluate the availability of evidence, rather than the achievement of standards; list the evidence as a function of the respondents' role in GP training, and; skip respondents to the next level once an evidence item for commendable or exemplary standards has been identified. Over 70% of the sample agreed that the GPCLE tool is relevant/compatible with GP, feasible for self-assessment, has value as a QI measure, and would be consistent with the work duties of those working in GP training. Over 70% agreed that the GPCLE tool could be used by anyone in GP training, prior to or at the commencement of training. Over 90% agreed that it should be used at 6 month (20%), 12 month (44%) or 2 year (23%) intervals.

Phase 3 – Pilot test.

Four GP training practices in diverse locations were invited to participate in the pilot study. Two were unavailable to participate within the pilot study timeframe (eg., additional governance requirements to visit an Aboriginal and Torres Strait Islander community). Two practices (MM1 and MM3) confirmed the value of the tool in GP training, with data from over 90% of the sample (N = 15) confirming that the GPCLE tool is relevant/compatible with GP, feasible for self-assessment, and has value as a QI measure. There was consensus among the pilot sample (100%) that the GPCLE tool could be used by anyone in GP training, and 90% agreed it was best used at the conclusion of training. Most agreed that it should be used at 12 month (67%) or 2 year intervals (27%). Qualitative interview data provided rich evidence about the context of use, and how the tool aligned with the needs of the practice team and learners, as well as informing revisions to the tool.

Data from the sector-wide review and the pilot study were triangulated to inform the final version of the tool (GPCLE tool V4) in June 2024, comprising 7 demographic questions, short instructions, and yes/no/unsure/not applicable answers to the availability of evidence for each of 11 sets of items, which aligned with the original GPCLE Framework. The standards depict satisfactory to exemplary levels of quality, with resources provided per item as a source of reflection. It takes around 20 minutes to complete.

Discussion

This mixed-methods project has produced a novel, co-designed tool by which to elevate the quality of the GP clinical learning environment. This is the first tool of its kind, developed by the GP training sector, for the GP training sector. The findings show that the GPCLE tool is perceived as highly acceptable, useable and feasible, providing strong credibility and support for implementation. The GPCLE tool will enable practices to measure, improve, and monitor their GP clinical learning environment.

Implications

The GPCLE tool can be applied by practices and accreditation bodies to systematise quality improvement expectations and engagement for new and experienced training practices, stimulating a strong learning culture within the practice and driving best practice. Moreover, the tool has broad policy implications for quality assurance purposes, such as College accreditation and university placement opportunities. Use of the GPCLE tool as a quality improvement and quality assurance tool will elevate GP training experiences and, in doing so, attract medical students and junior doctors to general practice as a speciality of choice.

Future research

The GPCLE tool was widely supported by the GP training sector as highly acceptable, feasible, and useable in GP training. Future research is needed to support the ongoing development of implementation resources alongside an engagement strategy to build momentum for practices to engage in quality improvement of the learning environment, using the GPCLE tool.

Citation: Toukhsati S, George T, Greenfield L and the GPCLE tool investigators. Supporting best practice in the GP Clinical Learning Environment: a benchmarking and quality improvement tool. Melbourne: General Practice Supervision Australia; 30th June 2024.