



# **Response to Department of Health and Ageing's Lead Clinicians Groups Discussion Paper**

**February 2011**

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Delivering local health solutions through general practice



AGPN represents a network of 112 local organisations (general practice networks) as well as eight state-based entities. More than 90 percent of GPs and an increasing number of practice nurses and allied health professionals are members of their local general practice network.

The Network is involved in a wide range of activities including health promotion, early intervention and prevention strategies, health service development and delivery, information and data management, chronic disease management, medical education and workforce support.

By delivering local health solutions through general practice, we aim to ensure all Australians can access a high quality health system.

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AGPN gratefully acknowledges the funding support from the Australian Government Department of Health and Ageing.

## Executive Summary

The Australian General Practice Network (AGPN) supports the overall drive of working towards ongoing improvement in quality and safety in health care delivery and, on this basis, gives in principle support to the ideas expressed in the Department of Health and Ageing's discussion paper on Lead Clinician Groups (LCGs). However, on the assumption that Local Hospital Networks (LHNs) and Medicare Locals (MLs) will have responsibility for clinical governance, engagement, consultation and leadership in the context of their roles and functions – which will include elements such as determination of best practice, dissemination of best practice guidelines and monitoring uptake - AGPN questions the merit of establishing an additional system of clinical governance and engagement structures as envisaged in the discussion paper. AGPN certainly supports the need for a more systematic approach to the development, dissemination and uptake of best clinical practice however suggests that funder expectations around LHN and ML roles and obligations in this arena are more clearly articulated before additional and potentially duplicative structures are set up. Once the clinical engagement and governance roles for MLs and LHNs are articulated, then the potential role for LCGs will be clearer. AGPN's responses are therefore predicated on there being a need for LCGs, although this is not a given. AGPN considers it crucial that the benefits of developing LCGs at both national and local levels, beyond the clinical governance/engagement structures currently in place or to be developed in LHNs and MLs, are made more explicit

Primary health care is the setting where most Australians get their health care: it must be considered on an equal footing to the hospital system. AGPN considers the discussion paper to have a hospital and acute sector orientation. Notwithstanding the comments above, should LCGs go ahead AGPN ideally supports the formation of a national LCG group with primary health care and hospital LCG sub-groups and for this structure to be reflected at the local level. AGPN believes this approach would be more consistent with the overarching policy objective of health reform which is to deliver a nationally unified, locally controlled prevention and primary health care-oriented health system.

Primary health care LCG subgroups would also overcome the risk of inadequate primary health care representation overall and would demonstrate commitment to engaging general practice, nursing and allied health providers in Medicare Local clinical leadership, strategy and operations. Primary health care LCGs are a more appropriate structure through which to engage clinical expertise in Medicare Locals than Board-level representation - a mode of engagement which has been advocated for by some provider groups. Primary health care LCGs should however be well linked and integrated with the Medicare Local's risk management processes of which clinical governance is a fundamental part.

AGPN also considers it important that, to avoid duplication, LCGs' roles and functions are clearly articulated and, wherever possible, LCGs work with or incorporate existing bodies currently performing similar roles and functions.

AGPN also views as critical that LCGs:

- distinguish between, and cover clinical engagement matters both in terms of clinical risk management processes as well as from the perspective of translating evidence into practice
- have strong links to implementation arms so that any frameworks developed can be implemented on the ground – although implementation in the primary care setting

may require a different approach to that in the hospital sector, given the level of private practice in the former.

In response to the specific questions posed in the discussion paper, AGPN makes the following key recommendations in addition to our general comments, that:

- ideally there should be dedicated National and Local Primary Health Care LCGs with appropriate liaison and communication channels between other LCGs and any equivalent groups in primary health care
- neither of the options proposed for national level clinical engagement is ideal. The key principle from AGPN's perspective is for the national group/s to focus on the two major settings for clinical care delivery being out-of-hospital primary health care and hospital care, with cross membership or some other means of information sharing and consultation between the two in terms of the configuration of the national LCG
- both levels of LCGs work collaboratively and synergistically with Local Hospital Networks, Medicare Locals and existing clinical engagement structures in developing best practice models
- the national LCG extends its role and responsibility to incorporate advising on auditing and monitoring of best practice uptake in addition to the roles proposed in the Paper
- The National and local LCGs are comprised of independent individual experts as well as representatives from existing organisations relevant to this field of work
- LCGs are funded through block funding to allow for flexibility and to complement a needs-driven focus
- Some funding is made available for implementation of best practice developments in the private sector.

## Introduction

AGPN welcomes the Government's initiative of enhancing clinical engagement in the promotion of continuous improvement in effective and quality health care delivery and in safeguarding high standards of care. AGPN believes that the General Practice Network and the incoming Primary Health Care Organisations (Medicare Locals) will play a key role in supporting and engaging with a range of health care providers - including those in the hospital setting - to facilitate the delivery of quality health care.

The role and function of Medicare Locals (MLs) has already been the subject of much national consultation and discussion. These discussions have emphasised the roles of MLs in population health/regional service planning, multidisciplinary chronic disease management, preventive health care, quality and safety and clinical governance – all areas that will benefit from a sound understanding of current clinical best practice.

As the peak body for general practice networks that are poised to transition into MLs, AGPN sees substantial potential for collaborative working between the LCGs and any such similar structures established within MLs themselves, including local clinical governance arrangements implemented as part of each ML's risk management processes. AGPN believes that such collaboration will play an important role in promoting the delivery of best practice in both the primary and secondary health care settings.

AGPN therefore welcomes the opportunity to submit this response regarding the development and proposed functions of Lead Clinicians Groups (LCG). AGPN's submission comprises two parts: A general section which outlines AGPN's broad comments regarding the LCG paper and concepts and a second part with specific responses to the questions posed in the discussion paper.

## General comments

AGPN supports the drive to ensure continued improvements in the delivery of health care and sees ongoing implementation of best practice as a key means through which to achieve this. AGPN supports initiatives which work towards ongoing improvement in quality health care delivery and on this basis gives in principle support for the underlying principles set out in the Discussion Paper (Paper). AGPN does however have several concerns regarding the paper:

- AGPN is mindful that, as outlined in the paper, a number of clinical engagement mechanisms already exist. To promote uptake of LCGs and their underlying principles, AGPN considers it crucial that the benefits of developing LCGs at both national and local levels, over and above the clinical engagement structures currently in place, are made more explicit. Currently these benefits are unclear in the paper.
- Bearing in mind that the governance and risk management arrangements for both Local Hospital Networks (LHNs) and Medicare Locals (MLs) will include clinical governance and that, in addition, LHNs and MLs will have their own clinical advisory and engagement structures, consideration must also be given to how LCGs will relate to these structures,
- AGPN considers it important that any LCGs set up at both the national and local level do not duplicate or fragment existing structures which perform similar roles but rather work with these groups as far as possible. One such structure which could be built on

or used as an alternative to LCGs are the health networks that operate in various states. These networks combine community, consumer and clinician views into frameworks for best practice models of care<sup>1</sup>.

- AGPN also emphasises, as a point of importance, that dedicated primary health care focused LCGs - including general practice and other allied health providers - are set up and, as outlined above, that these work closely with clinical governance groups within MLs. Although some mention of this is provided in the paper, AGPN believes that the importance of this collaboration and linkage needs to be given much more strength. In practice, effective collaboration between clinical governance groups in the primary and secondary sectors will be key to the success of the National Health and Hospital Network (NHHN) and will be critical to the success of many of the functions of LHNs as well as MLs, particularly in terms of service planning, hospital avoidance and other preventive programs, development of new models of care, quality referral pathways for patients with chronic disease, and more general population health outcomes. AGPN recognises that there may need to be some flexibility regarding LCGs in rural and remote areas where primary care can, at times, be delivered in the hospital setting.
- AGPN also considers it important to ensure that any LCGs established have clear connections to implementation arms, so that any principles, frameworks and guidelines developed by LCGs about best practice care can be translated on the ground. AGPN believes it important to distinguish here between implementation arms for the hospital sector and those for the primary care sector. Due to the different funding arrangements for these two sectors - the later of which more often incorporates private practitioners such as GPs and allied health providers - it is likely that successful implementation of best practice changes in the primary care sector will need to be incentivised to some extent (such as through the MBS, practice incentives or through a model such as the Australian Primary Care Collaboratives - APCC<sup>2</sup>).
- Although touched on in question 7, AGPN also considers it important to distinguish further in the paper between:
  - clinical engagement in terms of clinical input into clinical risk management, clinical planning and processes, sentinel events and the like and
  - clinical engagement in terms of implementing agreed best practice frameworks

## Responses to specific questions

### National LCG(s)

**Questions 1 and 2. What would the key role(s) of the National Lead Clinicians Group(s) need to include to effectively complement existing National level activity and in meeting the objectives described on page 4 of the Paper. Are there alternative/additional opportunities or roles to those identified in the Paper?**

AGPN supports a dedicated LCG for primary health care at both the national and local levels. AGPN also supports the proposal that the National LCG(s) would be responsible for acting as a conduit for both the systematic dissemination of best practice guidelines, and to play a key role in identification and prioritisation of evidence gaps. To support the use of evidence based best practice, AGPN also sees potential for the National LCG(s), in conjunction with Local

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<sup>1</sup> For further information, see: <http://www.healthnetworks.health.wa.gov.au/home/>

<sup>2</sup> APCC is a proven Continuous Quality Improvement methodology that has been successfully applied in a number of general practices across Australia. For further details see <http://www.apcc.org.au/>

LCGs, to play a role in facilitating auditing and monitoring of its uptake. Studies on clinical care pathways make it clear that simple dissemination of information is inadequate in ensuring best practice uptake, implementation and maintenance. Rather, they demonstrate that appropriate and ongoing care pathway use requires continuous monitoring, evaluation and reinforcement<sup>3</sup>. In the case of LCGs, this would entail linking to a funded program of implementation, so that health services can be supported to make improvements, advising on the measurement and analysis of best practice compliance and uptake across the country. This would allow for the identification of areas which could benefit from improved uptake and implementation of best practice guidelines, and would subsequently offer an opportunity for LCGs to work with other agencies to target and address existing and potential barriers to uptake and implementation.

AGPN also sees national LCGs as playing an important communicative and facilitative role among all stakeholders, including Local LCGs, LHNs, MLs, existing clinical best practice bodies, health care provider networks, all levels of government and health consumers. Effective communication will assist in minimising duplication of effort and improving the identification of evidence gaps. Composition of national LCGs in the format described under Q3 below would help facilitate this communication by ensuring that national LCGs have representation from key bodies which are already equipped with the necessary stakeholder/provider engagement and relationship management skills, and that have formal communication and engagement mechanisms in place.

There is mention in the Paper of LCGs taking on a health service planning and community needs analyses role. AGPN's strong advice is that LCGs' role in such instances would be advisory in nature in support of Local Hospital Networks (LHNs) and Medicare Locals (MLs), who will already be charged with the responsibility for clinical and service improvements under the National Health and Hospitals Reform Agenda.

**Question 3. How should a National Lead Clinicians Group(s) be structured and operate in order to provide optimal support to Local LCGs? How could a National LCG(s) best support clinicians, health care organisations and other structures under the NHHN reforms more generally?**

As stated above, AGPN strongly advocates for a dedicated national and local LCG focused on the primary health care system of care, including general practice. Neither of the options proposed for national level clinical engagement is ideal. Multiple groups focused on disease groups would not encourage a whole-of-patient view, nor necessarily look at practice and the patient journey across the primary health care-hospital/acute sector divide. Equally, one 'eminent' national group risks an over-representation from hospital and acute sector clinicians unless there are specifications and safeguards to ensure a balance. The key principle from AGPN's perspective is for the national group/s to focus on the two major settings for clinical care delivery - out-of-hospital primary health care and hospital care. A pragmatic option would be one national group with two LCG subgroups - one acute, one PHC - with this structure reflected at the local level, and also mirroring LHN and ML arrangements locally.

AGPN sees a role for the group in advising on cross disease issues - ie those issues that are common to a range of disorders - rather than becoming involved in disease specific issues,

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<sup>3</sup> Evans-Lacko et. al. (2010). Facilitators and barriers to implementing clinical care pathways. BMC Health Services Research; **10**:182.

especially as there are already a number of such groups who perform this task well. Focussing on cross disease issues would help align different disease groups into a whole system and assist in breaking down the currently siloed approach.

AGPN also sees a role for the national group in advising on the auditing and monitoring of best practice implementation and uptake. of effort, which would be achieved best through this model.

More specifically, AGPN sees the national level LCGs as an advisory committee with a dedicated secretariat. AGPN suggests that the committee be comprised of representatives from existing stakeholder organisations who currently work in this area, including for example, representation from the National Health and Medical Research Council (NHMRC), the Australian Commission on Safety and Quality in Health (ACSQHC), The national Institute of Clinical Studies (NICS) as well as from more specific primary health care and hospital groups. AGPN would see representation from organisations such as the Royal Australian College of General Practitioners (RACGP), the Royal College of Nursing Australia (RCNA), other allied health peaks, the Australian Primary Health Care Research Institute (APHCRI) and AGPN as key to a national primary health care LCG sub group.

Establishment of the National LCG in this way would support good communication to local LCGs through the use of existing organisational communication channels. (See Q4 also), especially if, where possible, local LCGs reflect the structure of the national LCG. Linkage from the national LCG to lead clinicians and decision makers in LHNs and MLs will also be important.

The National LCG(s) can best support its stakeholders by being the 'one stop shop' for all best clinical practice information. A web presence of the national LCG in its own right will be important in providing nation-wide information that can be well promoted and easily accessible. The national LCG(s) can also be proactive in communicating information through multiple communication channels, including, those available through its representatives' organisations. AGPN does not support a national LCG set up in multiple groups established to meet priorities in disease groups or other issues but does recommend, however, that time limited working groups may be convened by the national LCG to address specific issues or health priorities as the need arises.

**Question 4. What linkages (e.g. membership, information flows, work programming) would be required between the National LCG(s) and relevant existing organisations to embrace these opportunities/roles? How would this impact on a National LCG(s) model?**

AGPN has broadly outlined its suggestions for the composition of the national LCG above (see Q3) and recommends a mixed membership model comprising representation at an organisational level combined with the participation of individuals who are on the LCG in their own right as acknowledged experts. Organisational representation at this level will greatly assist in stakeholder engagement, participation, information flow and linkage and coordination with existing agencies with a stake in this area whereas individual experts will ensure the LCG can harness the best available expertise in primary and hospital based care and practice.

Of particular importance will be the relationship National LCG(s) have with peak provider network bodies. The Government's reform agenda specifically identifies the need for greater

engagement and consultation with broader multi-disciplinary providers. Representation of peak national provider network bodies on the National LCG as outlined above would promote this engagement and ensure an adequate level of communication and collaboration on a broad set of issues that are specific to the areas of expertise that these networks possess.

Regular membership reviews should be undertaken as part of the LCGs terms of reference and provision should be made to ensure the involvement of relevant future structures that are involved in clinical engagement activities.

A further consideration is the relationship of the National LCG (and a dedicated primary health care National LCG sub group should that ensue) to the national agency proposed for Medicare Locals. AGPN would suggest that the National LCG PHC subgroup should advise this body on clinical and quality issues pertaining to the anticipated role the organisation will have in ensuring innovation and consistency of delivery in primary health care initiatives and programs through MLs, mirroring our recommendation about the relationship between local LCGs and MLs.

## **Local LCGs**

### **Question 5. What are the opportunities for improved Local clinical engagement in achieving the objectives? What additional clinical engagement needs could be met by Local LCGs?**

An important opportunity for improved clinical engagement at the local level is in the interface between primary and secondary care. To achieve this, collaborative working relationships must be established between MLs, LHNs and LCGs. AGPN considers that the success of this relationship will underpin many of the opportunities for more general improvements in service planning/delivery and health outcomes at the local level. Once in place, these collaborative arrangements could provide a range of opportunities as follows:

- Opportunity for Local LCGs to support MLs and LHNs to meet their objectives of creating and maintaining a more integrated patient journey through the health care system as LCGs could act as a link between the primary, acute and aged care settings. To achieve this however strong relationships between LHNs and MLs will be required
- Specific to the primary health care sector, LCGs can work with MLs in identifying service and resource gaps within their communities. They can also help identify and address barriers to achieving a smooth transition for patients between care settings, and collaborate in efforts to address these barriers
- Local LCGs can also work with clinical governance structures established in MLs to improve quality and safety and help advise on best practice standards in ML program areas. With greater clinical engagement and subsequent liaison, MLs can better tailor primary health care programs that are specific to their communities' needs, and which are based on evidence and shaped by practicalities
- Local LCGs will also provide an opportunity to bring multi-disciplinary teams together in a collaborative way. As the move towards better integrated care gains momentum, Local LCGs can become a platform for providers to work together in determining best models of care based on a multi-disciplinary approach. This would also promote an effective

continuum of care across the entire health care landscape and would be best done under the auspice of the ML. It would require effective engagement with a broad range of primary health care provider networks.

**Question 6. What linkages (e.g. membership, information flows, work programming) could be made with existing structures to best meet the objectives? What linkages would be required between Local and National LCGs to allow each to effectively fulfil their roles?**

As discussed above, it is critical that Local LCGs are developed and run in a way that is complementary and synergistic to the efforts of existing structures. To achieve this AGPN believes that there must be formal stakeholder engagement mechanisms put in place between LCGs, existing best clinical practice structures and local provider networks.

**Question 7. To what extent does clinical engagement currently translate into decisions about clinical care? What are the factors that influence this (e.g. barriers and enablers)?**

GPNs across Australia run programs that are all about translating clinical engagement into decisions about clinical care in general practice. GPNs work at the general practice level on programs that are about improving the quality of care that is delivered there. Examples include e-health initiatives, including promotion of decision support, clinical audit tools that allow practitioners to review and monitor practice population health indicators and target improvements; practice nurse education, training and support; programs targeting improved prescribing and quality use of medicines; immunisation programs. The major strength of GPNs is their ability to attain clinical engagement with general practice (GPs, nurses and increasingly with other allied health providers). This helps inform decisions about clinical care. It also provides a conduit for general practice clinical input to the design of policies and strategies that are focused on both quality in general practice, as well as on how to better link with the wider primary care sector and with hospital-based care so that the strategies are achievable. Regular clinical engagement is provided through practice visits, continual professional development activities and continuous quality improvement activities at the local levels, including face-to-face as well as online learning activities. Evaluation of these activities generally suggests a translation of clinical learning and engagement into more informed clinical decisions. This is important, and resource-intensive work, because of the vast number of primary health care service sites. Evaluation of the use and promotion of other best practice activities within the network have shown that even where clinical engagement is good, other factors will limit the uptake of best practice interventions, particularly with GPs if:

- the intervention tools are difficult to use/paper based,
- there are no specific payments to promote their use and
- they are time consuming to use.

Thus, clinical engagement itself, although important, is not the only factor involved in determining the uptake of best practice approaches to care. Other factors, such as those mentioned above, must therefore be addressed to ensure the translation of clinical engagement into decisions about clinical care.

**Question 8. What local level investments would achieve the greatest progress towards the objectives of Lead Clinicians Groups? What form would this investment need to take (e.g. time, focus, funding etc? Should funding be block funding, project based funding, investment in tools, education or other activities)?**

To achieve the objectives outlined in the discussion paper, LCGs will need diversified local level investments. One of the barriers to adequate clinical engagement currently is the lack of opportunity caused by scheduling arrangements and a lack of financial incentive. These two areas must be considered a priority in initial and ongoing investments in LCGs. Clinicians participating in LCG activities must be given the necessary time away from their clinical duties to participate effectively, which may require investment and training in time management and administrative costs. For clinicians working in the private sector, such as general practice as well as a number of allied health practitioners, this needs to be complemented by a payment mechanism that funds clinicians for their LCG time so that clinicians do not risk losing income through their participation in an LCG.

AGPN believes the most effective funding model for LCGs would be block funding. In line with the Government's overall objective of delivering flexible funding models that are needs driven, block funding would offer this flexibility and promote greater ownership over clinical improvement policies and direction. This type of funding would also allow LCGs to determine needs regarding tools, education and other general activities which they may require to achieve their results in the most efficient and effective manner.

AGPN would stress again that clinical engagement in a hospital context is different to that in general practice and primary health care. The key issues for general practice centre on how best engage clinicians to implement quality improvement given the large number and varied nature of general practice service sites, current programs in place (such as National Prescribing Service programs, PEN Clinical Audit Tool) and the need for each practice to be convinced of the intrinsic worth and supporting business case to enable its involvement in quality improvement (there are not the same organisational supports and reporting requirements that exist in hospitals). To embed a CQI culture, AGPN would strongly encourage the Government to consider linking local LCGs with a proven continuous quality improvement (CQI) implementation model such as the Australian Primary Health Care Collaboratives (APCC). Without a link to an implementation program, there is a strong risk that little real improvement will be achieved.

**Question 9. What communication pathways should be established from the National Lead Clinician Group(s) and State-wide committees/structures, to Local Lead Clinicians Groups?**

AGPN has already outlined in broad terms the structure of a national LCG advisory committee comprising individual experts and representatives from existing relevant national organisations. AGPN considers this structure will provide its own inherent communication and information dissemination pathways through representative's member organisations which in turn could link to state-wide and local LCGs where these follow similar structures to the national committee.

In addition, as a peak network representative, AGPN utilises a number of effective tools to communicate with its members. We therefore recommend the consideration of some of these for use between the LCGs and incumbent state-wide structures:

- A continuously updated website with blog features
- A quarterly newsletter
- Webinars
- Email lists
- Regular teleconferences
- Half yearly/yearly forums
- Round tables