



**Australian  
General Practice  
Network**

## **Submission to the Australian Government's *National Health Reform: Lead Clinicians Groups Proposal***

**June 2011**

Delivering local health solutions through general practice

25 National Circuit Forrest ACT 2603 | PO Box 4308 Manuka ACT 2603  
**T** 02 6228 0800 | **F** 02 6228 0899 | [www.agpn.com.au](http://www.agpn.com.au) | ABN 95 082 812 146

**Delivering local health solutions through general practice**  
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The Australian General Practice Network (AGPN) represents a network of 111 local organisations (general practice networks), as well as eight state and territory based entities. Collectively these organisations are known as the Network. More than 90 per cent of general practitioners and an increasing number of allied health professionals and practice nurses are members of their local GPN. The Network is involved in a wide range of activities, including health promotion, early intervention and prevention strategies, health service development and delivery, chronic disease management, data management, medical education and workforce support.

Australian General Practice Network

PO Box 4308

MANUKA ACT 2603

AUSTRALIA

Telephone: +61 2 6228 0800

Facsimile: +61 2 6228 0899

Email: [agpnreception@agpn.com.au](mailto:agpnreception@agpn.com.au)

Web: [www.agpn.com.au](http://www.agpn.com.au)

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## Key Points

- **AGPN, in-principle, supports the rationale and proposed governance and functional arrangements for the Lead Clinician Groups (LCGs)**
- **LCG objectives should include complementing the work of Medicare Locals in their role of coordinating and encouraging collaboration between different primary health care providers**
- **LCGs will need the capacity to engage with 'grass roots' providers to be informed about local clinical issues and to enact their work.**
- **Nationally-led, locally delivered initiatives to facilitate the formation provider networks and to train and support clinical leaders will be key enablers for the aims of LCGs but for the primary health care reform agenda more broadly.**
- **Sufficient primary health care participation on both the National LCG and Local LCGs is fundamental.**
- **Time-limited working groups of the National LCG would expand its level of expertise where necessary and allow it to address unique, difficult and/or pressing matters.**
- **Utilising and integrating with existing Division of General Practice boards and/or existing clinical advisory arrangements as well as planned Medicare Local clinical advisory structures will allow local LCGs to begin operation in a timely manner.**
- **AGPN supports the notion that at least 75% of the membership of LCGs should be practicing clinicians and suggests that any final guidelines should strongly encourage the involvement of an even greater proportion of practicing clinicians.**
- **The Commonwealth model appears to assume a 1:1 relationship between the Medicare Locals and Local Hospital Networks (LHNs). Guidelines will need to canvass and take into account the practical aspects of implementing LCGs in regions where there is more than one LHN per Medicare Local boundary.**

## Introduction

The Australian General Practice Network (AGPN) welcomes the opportunity to provide feedback on the Australian Government's *National Health Reform: Lead Clinicians Groups* proposal. We are pleased to find that, on the whole, the advice and recommendations made by AGPN in its submission to the Commonwealth's initial discussion paper: *Lead Clinicians*

*Groups: Enhancing Clinical Engagement in Australia's Health System*, have been incorporated or considered in informing the proposed Commonwealth model.

AGPN is, in principle, supportive of the rationale and proposed governance and functional arrangements of the Lead Clinicians Groups (LCGs). We consider the most important aspects of the LCGs is their potential to improve the patient journey by acting as a point of collaboration between multidisciplinary, multisectoral health care stakeholders, and to assist in developing and implementing clinical standards and guidelines to improve safety, quality, efficiency and effectiveness in health care delivery.

AGPN supports the view that LCGs will play a complementary role in care coordination with their Local Health/Hospital Networks (LHNs) and Medicare Locals. In particular we support the Government's proposal that LCGs will:

- act as 'champions' to promulgate and promote optimal care and referral pathways and innovative local initiatives that integrate and coordinate care solutions;
- complement the work of Medicare Locals in their role to coordinate and encourage collaboration between different *health professionals* on the patient journey; and
- provide advice aimed at facilitating the better integration of services, aiming for improved coordination of service delivery.

We would point out that the last objective nominated for LCGs should be concerned about complementing the work of Medicare Locals in their role to coordinate and encourage collaboration between different *primary health care providers* – not medical practitioners alone as the statement on page 4 suggests.

This submission focuses on supporting and discussing a number of the key proposals presented in the consultation paper, as well as presenting several points of discussion around areas that AGPN believes warrant further consideration particularly with respect to the implementation of LCGs.

### **Local provider networks and clinical leadership capacity**

Local LCGs will need to engage with broad 'grass roots' level local health care provider networks to: (1) be informed by the full range of locally specific, multidisciplinary issues and experiences; (2) build and maintain strong local, cross-sectoral referral pathways; and (3) adequately disseminate, and ensure widespread and consistent implementation of, LCG

recommended/advocated policy. By local provider networks, we mean organised groups of local multidisciplinary primary health care providers that come together on a semi-formal basis to interact around areas of need or common interest; the purpose of which is to build multidisciplinary relationships, build and strengthen local referral pathways, address clinical issues from a multidisciplinary perspective (through case discussion for example), communicate and disseminate evidence based models of care and provide general collegial support. Such networks could be modeled on the Mental Health Professionals Network. More information on the MHPN can be found on its website: [www.mhpn.com.au](http://www.mhpn.com.au)

It is our understanding that in working to achieve their aims, local LCGs will work at the meso LHN/ML level of the health care system, and that each local LCG will have a membership and/or participatory restriction on numbers for functional reasons. With this in mind, we recommend that further consideration needs to be given to how local LCGs can adequately engage with the breadth and depth of the broader primary health care provider community without networks of organised and mobilised 'grass roots' private primary health care providers.

General practice has had the benefit of the Divisions of General Practice Program (DGPP) to assist its local organisation – and this level of support for general practice is to be retained through Medicare Locals 'subsuming' the objectives of the DGPP. Practice nurses, to a lesser extent, have had similar support, although on a much smaller scale, through the Nursing in General Practice Program. Currently, however, many primary health care professions/professionals are not adequately organised to communicate effectively with each other or with meso-level bodies such as Medicare Locals. The fact that many primary health care providers operate privately, and often by themselves or in very small groups, mean that many are relatively isolated from external engagement and communication, other than that received through their professional bodies.

This has considerable implications for achieving and maintaining the broad multidisciplinary integration of health care providers and services that the Commonwealth is seeking to attain; risking the continuity of care for health consumers and the Government optimising its health reform objectives. In addition, the absence of these networks in many areas, or their variability in others, will impede the local LCGs capacity to inform and disseminate relevant policy at the grass roots level.

It is the case that Medicare Locals will have an obligation to improve linkages and relationships between all primary health care providers as well as specialists and all will have various plans through which this will be achieved relative to their local circumstances. AGPN understands that the formation of these provider networks is out of the scope of the LCGs proposal, and is primarily a separate matter for Medicare Locals to consider and implement. However, to be effective, there is good evidence that to drive the range of objectives specified for LCGs, supported peer networks, clinical leadership within the LCG itself as well as the service systems it wishes to influence and external support from meso level organisations such as Divisions and Medicare Locals will be required<sup>i</sup>.

With regard to peer networks in particular, there is good evidence that, if properly resourced, these networks can support practitioners to develop innovative ways of implementing evidence based models of care and/or developing solutions to service problems. Semi-formal peer networks supported by Medicare Locals (and Divisions as they transition) are well placed to develop and support such networks<sup>ii</sup>. Such an approach will be an enabler for the work of the LCGs. AGPN therefore believes there is merit in a time-limited national initiative, built on the model and infrastructure of the Mental Health Professionals Network, in order to 'seed' and support the formation and sustainability of local provider networks.

In addition, AGPN believes it is important that investment is made in leadership training and development for clinicians, particularly those involved in LCGs but more generally for those involved in clinical leadership roles within overall Medicare Local and LHN governance arrangements. A recent systematic review found that many practitioners are placed in clinical governance leadership roles with little support or training and that there is a need to develop ongoing education for clinical leaders<sup>iii</sup>. This was echoed in an independent consultancy report commissioned by AGPN which reviewed organisational and leadership capacity and requirements following the implementation of Primary Care Trusts in England. This Review considered learnings for the Australian context and found, among other things, that clinicians may need specific practical support to engage at a board and governance level<sup>iv</sup>.

We believe that both these measures will be key enablers for the aims of the LCGs, but more importantly for the primary health care reform agenda more broadly. In consultation with the National Primary Health Care Partnership, AGPN is preparing supplementary advice and proposals on these two matters for the Department's consideration.

## **LCG governance**

### **National LCG**

AGPN supports the proposal that the National LCG will advise and report to the Federal Minister for Health and Ageing. There is however no mention of the relationship that the National LCG will have with a Medicare Local national level organisation. The Australian Government, in its Medicare Local Invitation to Apply, clearly articulates the need for national level support for the Medicare Locals network. This national level body would be invaluable in assisting and working with the National LCG in ensuring the determination and dissemination of nationally consistent and robust policy across the primary care setting. Along with other national stakeholders, it could also work with the National LCG in identifying priority areas, determining strategies for the dissemination and implementation of national clinical standards and guidelines, and identifying issues to be flagged with the Minister.

As the Government outlines in its proposal, the local LCG members will be appointed by the relevant LHN and Medicare Local boards, reserving two places to be directly appointed by the appropriate Medicare Local to ensure adequate primary health care input and participation. This should also apply to the National LCG. It would be both logical and beneficial to have the National LCG's structure reflecting that of the local LCGs and to have the same assurance that primary health care participation will be adequately reflected in the composition of the national LCG.

Unless there is a sufficient primary health care presence in the National LCG it may be difficult for local LCG primary health care members to communicate issues at the national level specific to their sector and service setting. There is also a risk that the National LCG agenda will be subsumed by the acute sector rather than having a more balanced, whole-of-system view. AGPN believes that primary health care participation on the national group will be a particularly potent way of this group examining the particular challenges and opportunities to improve pathways, integration and communication between providers at the primary health care/hospital interface. We agree that the Minister should have final appointment authority of the National LCG.

AGPN further believes the support of time limited working groups for the National LCG would expand its level of expertise where necessary and allow it to address unique, difficult and/or suddenly pressing matters, and thus welcomes this proposal. The Medicare Local national organisation could play a role in identifying participants. AGPN sees value in more explicitly illustrating the relationship that the National LCG will have with the proposed national

Medicare Local organisation as well as other parts of the national health architecture in the Government's final LCGs model.

### **Local LCGs**

AGPN supports the proposed local LCG governance model however the process by which LCG members will be nominated and selected is unclear. Having local LCGs report to their appropriate LHN Governing Councils and Medicare Local Boards will ensure relevance, responsiveness and local accountability. It will also facilitate and promote effective collaboration between these bodies. Having the CEOs of the LHNs and Medicare Locals attend each local LCG meeting, and having the minutes of each meeting copied to their respective LHN Governing Councils and Medicare Local Boards will ensure the relevant parties are 'on the same page' around multidisciplinary and multi-sectoral issues, and we thus encourage this model's implementation.

AGPN is also supportive of the local LCGs proposed appointment process. Having at least two members of the local LCG directly appointed by the relevant Medicare Local Board will ensure adequate primary health care input, as well as foster greater cross-sectoral (acute/primary) collaboration. Having this requirement as a condition of Commonwealth funding will ensure its compliance.

Utilising existing Divisions of General Practice Boards and/or existing clinical advisory arrangements from which to draw clinicians to support local LCG governance functions until the relevant Medicare Local is established will allow local LCGs to begin operation in a timelier manner, and will thus facilitate greater national consistency in policy implementation. Division Boards and/or their local clinical advisory mechanisms are the most appropriate governing bodies due to the fact that many (almost all) are evolving into Medicare Locals and they have experience, infrastructure, expertise and existing relationships in and with the medical and primary health care professional sector.

### **Membership**

AGPN agrees with the proposed LCG membership model. We would however like to emphasise the importance of the Commonwealth's intention to have multidisciplinary and multi-sectoral members to harness the knowledge and skills of a wide range of health related modalities, in addition to the added benefit of collaborative relationship building. We also welcome the Commonwealth funding requirements of having the local LCGs chaired by a

practicing clinician; and that they include at least one consumer representative. It is also highly important to allow flexibility for local LCGs to better reflect the local circumstances of the communities they represent. We support the notion that at least 75% of the membership is practicing clinicians and would suggest that any final guidelines should strongly encourage the involvement of an even greater proportion of practicing clinicians.

### **Implementation/evolution**

The Government proposes to evolve existing clinical governance bodies into local LCGs, subject to them meeting the Commonwealth's minimum funding requirements. As discussed above, AGPN supports this notion for a number of reasons, particularly because it reduces the risk of duplication and harnesses the skills, expertise and relationships that have already been established. Evolving existing clinical bodies into what the Commonwealth requires however may be complicated in some instances.

For some existing bodies, meeting Commonwealth funding requirements may entail a substantial restructuring of its membership, including around the percentage that are practicing clinicians and whether the membership is considered multi-disciplinary and multi-sectoral. Some may also be required to replace their existing Chair if they are not practicing clinicians. This may have considerable implications if the composition of membership is difficult to alter, requires a certain length of time to do so, or if the Chair has an agreed term of tenure.

In addition, and as the Government recognises in its proposal, many existing clinical governance/advisory bodies are state/territory convened and funded. A change of governance arrangements in these clinical bodies in order to meet Commonwealth requirements may in fact conflict with what the state/territory requires for its purpose/funding. If this conflict was not to be resolved and Commonwealth funded local LCGs were established in parallel, there would be an obvious potential for duplication. AGPN expects that the Commonwealth is considering these scenarios in its negotiations with the relevant state/territory authorities.

A number of existing committees, especially those in large hospitals, also have a very different focus to that envisaged for LCG's in that they are charged with reviewing individual cases in the context of the system rather than the broader coordination roles. This will require a fundamental change in approach. Indeed these clinical review committees may

need to remain in some form, so care must be taken in being very clear about the purpose of the LCGs.

The Commonwealth's model appears to assume a 1:1 relationship between Medicare Locals and LHNs. Guidelines will need to canvass and take into account the practical aspects of implementing LCGs in regions where there are multiple LHNs per Medicare Local boundary.

## **Evaluation**

AGPN supports the Commonwealth's commitment to evaluate the design, governance and functional performance of LCGs. We propose that an evaluative framework be built into the LCGs governance structure from the beginning, and that at the very least, an interim evaluation be carried out no later than 18 months post establishment. The LCGs are an entirely new concept in Australia, and are in addition being implemented under a new health care paradigm in this country. The concept appears sound, but if aspects of the model require refinement during the early stages, three years is much too late to identify and address any problems or areas for improvement.

AGPN welcomes the opportunity to discuss any positions taken in this submission with you further. To arrange any future discussion or to follow up on any queries regarding this submission, please contact Leanne Wells on (02) 6228 0854 or email at: [lwells@agpn.com.au](mailto:lwells@agpn.com.au).

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<sup>i</sup> Phillips C et al, (2010) Improving Quality Through Clinical Governance in Primary Health Care. APCHRI, Australian National University

<sup>ii</sup> ibid

<sup>iii</sup> ibid

<sup>iv</sup> Cronin E (2010) Primary Health Care Organisations (PHCO) Leadership and Organisational Development in Australia: learning from England.