Primary health networks and leadership for quality improvement

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EDITORIAL

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Developed countries around the world are grappling with the issue of delivering high quality, sustainable health care. They have seen the cost of health care rise over the last 20 years. Each of the countries has experienced healthcare reform with respective policies aiming towards a value-based healthcare delivery system, and the recent Reform of the Federation agenda in Australia has articulated the requirements for the health system (Figure 1).[1] Primary care has been a central part of the delivery system for most of these developed countries with observational research confirming the value of primary care offering first-contact, comprehensive, coordinated, and continuous care.[2] Paradoxically, at the same time primary care and general practice has been subject to criticism resulting in a series of reforms towards more organised primary care through the formation of meso-level primary health care organisations (PHCO).

In Australia, Primary Health Networks (PHNs) are the third and latest iteration of PHCOs, and have been specifically charged with two objectives around improving the efficiency and effectiveness of health services for patients and coordination of care.[1] Achievement of these tasks will be through commissioning and will require alignment with needs of

health services, system redesign, and transformational change supported by a framework of enablers. However, success will ultimately depend on the ability of PHNs to influence quality improvement and change in clinical behaviour at the sharp end. The successful and effective change of clinician behaviour will need strong clinical leadership for quality improvement, for which there are lessons to be learnt from the non-healthcare sector, internationally from experiences of other countries that have also formed PHCOs, as well as from Australia's own previous experience with PHCOs.[3]

Figure 1: Ideal health system

An ideal health system is:

- Centred on the patient's health and well-being;
- Safe, provides the right care, in the right setting, at the right time, and supports prevention and early intervention;
- One where consumers are empowered to manage their health and health risks, and to make healthcare decisions;
- Fair and supports disadvantaged and vulnerable people and communities;
- Operates effectively, delivers value for money, and eliminates waste;
- Flexible for innovation, adaptable to meet local circumstances, and encourages continuous improvements in services;
- Anticipates and responds to the needs of an ageing population;
- Measures success and aligns incentives with people's health and wellbeing; and supported by clear roles and responsibilities so the public can hold governments to account.

Clinical leadership is a complex activity that has been researched extensively and at it's simplest "is the act of any person or group to influence others" to improve patient care.[4] Arguments against the case for clinical

leadership often cite the lack of evidence that clinical leadership has any impact on achieving improvements. There are certainly significant research gaps in this area, particularly in relation to actions by leaders to improve primary and community services and coordination of care.[5] However, there is strong evidence that not engaging clinicians has negative consequences on improvement projects and as far as commissioning is concerned "there is strong evidence to suggest that effective commissioning requires a collaborative effort between commissioners and providers, especially through clinical engagement".[6] Furthermore, there is emerging evidence of the value of leadership. For example, Goodall found a strong positive association between physician leaders in hospitals and the hospitals' higher ranking on quality measures.[7] Notwithstanding the research gaps, there is strong consensus and observational evidence to suggest that successful organisations attribute their success to strong clinical leadership. A report based on United States experience informing the development of Clinical Commissioning Groups (CCG) in England strongly recommended the need for GP consortia to invest heavily in leadership and training for GP leaders.[8] In a commentary of New Zealand's PHCOs, researchers attributed their success to being clinically led change management organisations.[9]

Dawda et al. described actions required at multiple levels for quality improvement in English general practice[10] and others reviewing quality improvement initiatives across the UK and US have described four levels, each of which requires the development of clinical leadership.[11] In discussing leadership for quality improvement, a recent review concluded that what may be successful "are leaders' actions which galvanise the sustained effort of other leaders and personnel to work on improvement ('alignment') or a 'collective leadership' approach".[12] Developing and harnessing clinical leadership at all four levels provides one facet for a collective leadership approach.

The first level of quality improvement is at the individual level. This level takes a craft-based paradigm of quality improvement in which the individual clinicians, their knowledge, and technical expertise are the drivers for high quality. Multiple agencies support the development of individuals in general practice, including professional colleges, hospitals systems, pharmaceutical companies, and PHNs. The professional colleges have a continuous professional development program and regulatory agencies have begun to explore revalidation in Australia. In a study of CCGs in the UK, researchers found strategies of education, training, and facilitating comparative performance data at this level were acceptable to general practitioners.[13] However, education

itself, though necessary, is insufficient to achieve the vision and objectives of the health system at large and this fact has been acknowledged in the Australian context.[14] It is far more likely to be effective only as part of a multi-faceted approach.

The second level of improvement occurs at the team or microsystem level. A microsystem has been described as the basic building block of health systems and is said to be formed "as soon as a patient is in a relationship with a health care provider—and information about the patient and the patient's health need is exchanged with the provider".[15] This shifts the thinking from a craft-based approach towards a system-based paradigm. A study observing the traits of high-performing primary care clinical microsystems found engaged leadership to be first building block towards being high performing.[16] Six recommendations for leaders involved in improvement of primary care microsystems have been suggested:[17]

- Embracing a leadership paradigm
- Walking the talk
- Aligning improvement with outcomes that matter to patients
- Developing a team-based approach to care
- Using source of power through position, knowledge (of quality improvement), and persuasion to influence others in the system
- Self-reflection to improve their own leadership skills.

Experience from English PHCOs suggest strategies, including financial incentives to support quality improvement and the development of referral pathways and protocols as acceptable to GPs.[13]

PHNs are in a unique position to develop and support leaders in microsystems. However, this will first and foremost require PHNs to have an ability to identify who the leaders are in those clinical microsystems, then engage with them before embarking on any form of leadership development support.

The third level of improvement is at the organisation level. This includes provider organisations but also within PHNs themselves and their core function of commissioning. Authors have cited the lack of consistent external drivers for continuous improvement, lack of physician involvement, and insufficient senior management leadership and support as barriers at this level.[11]

In Australia, accreditation of general practices (with financial incentives for accredited practices) provides an external driver, however, the scheme is voluntary and the ensuing incentives are a relatively low percentage of total practice revenue. Accreditation has shown improvements in some practice processes, but the impact on patient outcomes and overall improvement of quality and safety is more difficult to determine.[18]

The Australian Primary Care Collaborative is a quality improvement program that has engaged 83 per cent of Divisions of General Practice (the first PHCO structure in Australia) and 16 per cent of general practices have participated.[19] The reasons for high engagement of PHCO but relative low percentage for participating general practices would be very useful to guide PHNs' engagement strategies and suggests the need for additional approaches to achieve wider engagement.

PHNs will be commissioning organisations. Examples of commissioning already exists in Australian primary care, but the formation of PHNs makes it a central activity for these new organisations with the potential to improve public value.[20] In the UK, CCGs have a dual purpose: to commission services and to support improvement in the quality of care in general practice. This second role is considered crucial given the gatekeeping function of general practice, the increasing focus on management of long-term conditions and the need for integration requiring new models of general practice and care delivery.

A number of actions for quality improvement were recommended for CCGs and those same actions are applicable to PHNs.[10] These actions are essentially leadership activities that include creating a local vision, a culture of innovation, and aligning resources and providing enablers to achieve that vision. The mandated structure for every PHN includes a Clinical Council and a Community Advisory Group to advise the Board. The magnitude of patient safety and quality issues in hospitals led to suggestions that Boards should perform the same high level of oversight for quality and safety as they do for finance.[21] The same will be necessary for PHN Boards if they are to deliver their objectives. Boards have a function in creating the "will" to improve quality and safety, maintaining constancy of purpose, and driving execution through rigorous oversight of management teams' performance. Strategies on how to do this have been well documented.[21]

The Clinical Council can support the generation of ideas to improve quality and safety. However, critical to the successful implementation of such ideas will be wider clinical engagement. The levels of engagement are variable and the English experience suggests four groups ranging from those who are highly engaged (minority), through to passive supporters, largely disengaged followers, and active dissenters.[6] The majority were in the two middle groups and larger PHCOs had lower levels of engagement.[13] This is particularly relevant in Australia as the total number of PHNs is less the number of entities under previous iterations of PHCOs, which means that PHNs are covering larger areas. Commentators have suggested "strong clinical leadership does not ensure the engagement of rank and file GPs," however, "maintaining broader engagement is indicative of successful clinical leadership".[22]

The fourth level relates to the larger system and environment and the macro-level changes required to support the other three levels. PHNs have two roles in this area by using the experiences of frontline workers to inform policy but also through being bold enough to collaborate and pilot new ways of working with robust evaluations to inform future policy. For example, an award-winning CCG in the UK underwent a successful transformation program. The evaluation showed improvement across a basket of indicators. One of the lessons they shared was the need for a strong and bold leadership demonstrating diplomacy, the ability to listen, firmness under pressure, the willingness to role model, and strategic foresight.[23]

The organisation of primary health care in Australia through supportive meso-level PCHOs, the PHNs, holds enormous potential, but a critical success factor will be the successful and appropriate engagement of frontline clinicians and GPs. This requires a structured and systematic approach to developing an engagement plan. The evidence from the international experience and past Australian experience may inform what should be included in such a plan, but adaptation to the local context will be paramount. To successfully adapt it to the local context, PHNs should consider the level of engagement required from its membership, measure the level of engagement they have, and then develop and implement a multi-faceted strategy to improve the degree of engagement. In doing so, they will need to consider the heterogeneity of general practices and the four levels of quality improvement to produce an appropriately segmented engagement strategy. Co-designing the strategy with GPs will stack the deck of cards in their favour and to achieve all of this will require

a vision, will, and resources. However, in doing so they will achieve the collective and distributed leadership required for quality improvement to achieve their objectives of improving effectiveness and efficiency of health services.

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CONFLICTS OF INTEREST

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