Victorian Healthcare Association

SUBMISSION

National Health Reform: Lead Clinicians Groups Position Paper

17 June 2011

1. Introduction

This submission outlines the Victorian Healthcare Association's (VHA) response to the *National Health Reform: Lead Clinicians Groups Position Paper* (the Paper). The VHA agrees to this submission being treated as a public document.

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The Victorian Healthcare Association

The VHA is the major peak body representing the public healthcare sector in Victoria. Our members include public hospitals, rural and regional health services, community health services and aged care facilities. Established since 1938, the VHA promotes improvement of health outcomes for all Victorians, from the perspective of its members.

2. The VHA's Response

The VHA supports, in principle, the establishment of Lead Clinicians Groups (LCGs) and the aim of creating a structure to enable greater input by clinicians into healthcare provision at a strategic/system wide level to "*promote evidence based clinical practices and assist with the prioritisation and implementation of clinical standards and guidelines*".

The VHA is concerned by several aspects of the system as described in the Paper, namely the way the system is structured and the relationships between national, state and local bodies, and the overall lack of clarity around the structure and operation of local LCGs.

Proposed Commonwealth Model

The Paper provides a diagrammatic representation of the proposed model for the clinical advisory system. The model shows a two way conduit between the National LCG and local LCGs, as well as a two way conduit between local LCGs and existing state based clinical advisory groups/structures. It does not show any direct relationship between the state based groups and the national LCG (Figure 1, p3).

This proposed model places an untenable amount of work and responsibility onto the local LCGs. Under this model, local LCGs are expected to "[implement] national and state clinical standards within its respective partner Local Hospital Network (LHN) and Medicare Local(s)". This is a high expectation in terms of time commitment and expertise for local groups to analyse and reconcile national and state guidelines and implement them at a local level. It also leads to unnecessary duplication of work across multiple locations.

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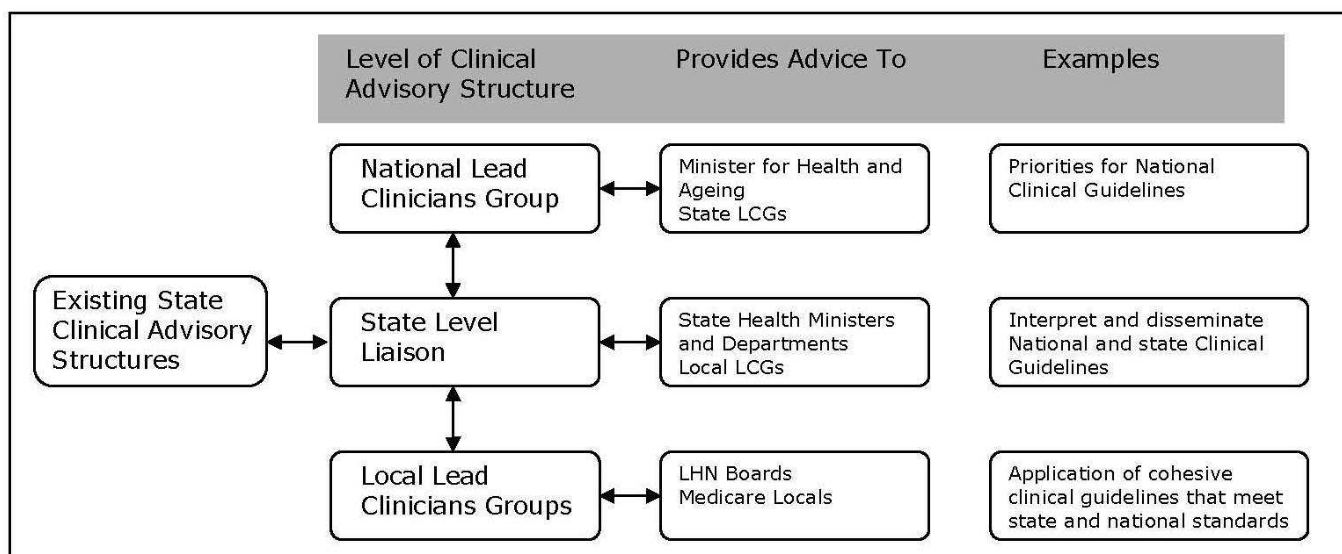
Existing state based clinical advisory groups are often issue or discipline based, without a broader strategic overview of the health system as a whole. There is a risk of further fragmentation of clinical advice causing confusion for the LCGs.

The application locally of national strategies that have been interpreted in a state context is a more realistic and productive use of local LCGs. This structure would also allow for better sharing of successful mechanisms for dissemination of information locally and application to various local circumstances, via a state level liaison, thus potentially further decreasing duplication.

The VHA proposes the model below to illustrate the preferred mode of interaction between the various levels of clinical advisory structures. This model does not duplicate the existing state level clinical advisory structures, but rather provides a state level liaison to interpret and disseminate national and state level clinical guidelines to local LCGs, who can then apply them to the local situation. State liaisons would be funded via the national system and have clearly defined responsibilities to the national LCG, the local LCGs in their jurisdiction and to the state based clinical advisory structures. The liaison should have expertise in clinical governance, quality and safety.



Operation and responsibilities of local LCGs

The VHA is concerned about the operation and responsibilities of local LCGs as outlined in the Paper. Although the VHA welcomes the inclusion of clinicians in the implementation of clinical guidelines, the scope of the responsibilities of local LCGs will be an onerous burden on participating clinicians, particularly in areas of workforce shortage.

Membership: The Paper states that 75 per cent of the membership of the local LCGs will be made up of practising clinicians, including the chair. It also states that the Chairs of the local LHN and Medicare Local (ML) will attend meetings (although it is unclear whether they will be members of the LCG) and that the membership will include at least one consumer representative. This leaves little room for

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representatives with expertise in clinical governance and quality and safety, and the VHA is concerned that without such representatives local LCGs will not be able to achieve the stated aims.
There are also concerns around the competency and capacity of local LCGs to successfully undertake this type of work. This is especially true of rural areas, where a shortage of health professionals already exists and clinicians are often already overburdened.

Appointment Process: The Paper states that the appointment process will be transparent and undertaken by the LHN Governing Council and the ML Board, however there is no indication of how this process will occur. It also states that two members must be appointed by the ML Board, however it is not articulated how this is to occur and whether they will be practising clinicians or representatives of the ML Board. It is also unclear how this requirement will be fulfilled if a local LCG is operating in more than one ML area.

Administration: The Paper provides no indication of how the administrative work of the local LCGs will be undertaken, and what (if any) funding will be provided to do this. Significant time will need to be allocated to tasks such as organising meetings and coordinating participant schedules, minute taking and dissemination. Presumably, local LCG meetings will also generate a number of items to be actioned and it is unclear how this will be achieved (especially given the membership is primarily comprised of busy practising clinicians).

Coverage: The Paper does not clearly outline how the boundaries of local LCGs will be established as the process for deciding whether a LCG will cover more than one LHN is not mentioned. Although the Paper states that if the LHN covers more than one Medicare Local then "clinicians practising within the LHN boundary" should be included in the local LCG, the current appointment requirements will complicate matters.

This is even more problematic for "functional LHNs", such as specialty children's or women's hospitals, which often cover an area across the entire state.

3. Conclusions

The VHA supports increasing the involvement of clinicians in the operation of the Australian health system. LCGs could be an effective method to achieve this, however, the proposed system must take into account the need for a state level liaison to align national and state clinical guidelines and disseminate them at a local level. Additionally, the responsibilities, authority and governance structure of each level of LCGs needs to be elaborated in order for them to have an effective and sustainable role in the ongoing improvement of Australia's health system.

Please contact me on (03) 9094 7777 to clarify any information in this submission.

Yours sincerely

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