



AUSTRALIAN PRIMARY HEALTH CARE RESEARCH INSTITUTE

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MANAGING CHANGE IN PRIMARY CARE: THE CONTRIBUTION OF A CLINICAL LEADERSHIP PROGRAM

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INTRODUCTION

POLICY CONTEXT

A comprehensive review of health policy by the Rudd government has resulted in two reports relevant to the introduction of clinical leadership for primary care in Australia. These reports are the National Health and Hospital Reform Commission¹ and the National Primary Care Strategy.² The former called for clinical leadership training. At the time of writing, policies have not been finalised but it can be assumed that the emphasis will be on integration of care, improve teamwork particularly for chronic disease management, new primary healthcare organisations including comprehensive primary care clinics and an emphasis on clinical governance.

OVERVIEW OF THE ORGANISATION OF PRIMARY CARE

Australian general practices voluntarily group in Divisions of General Practice which in turn form state-based organisations and at the national level, Australia General Practice Network. A new policy may mean changes to these structures and their functions but it is likely that many who have been leaders in the divisional network will continue to lead for some years.

An important recent contributor to improving primary care has been the Australian Primary Care Collaboratives which has offered workaday GPs, practice managers and nurses an opportunity to display their leadership talent.

THE IMPORTANCE OF CLINICAL LEADERSHIP

In Stream Six, we conducted a systematic review of the evidence on the contribution of approaches to organisational change in optimising the primary care workforce.³ We also conducted interviews in Canada, Netherlands, New Zealand and UK. We concluded that efforts to change clinical practice by influencing individuals have proved ineffective unless the organisation in which they work is ready to change. It is clear that performance in healthcare organisations is inextricably linked to leadership, culture, climate and collaboration. We recommended the establishment of a small expert centre for clinical leadership working with leading divisions and practices on real change problems in real-time to optimise the delivery of chronic disease management across organisational boundaries. There is evidence that clinical leaders can improve teamwork, communication, integration and coordination, especially through the building of clinical networks.

In Stream 10, we visited the USA to study clinical leadership at Dartmouth Medical College, Harvard Business School, the Institute for Urban Family Health in New York, the McLelland Institute in Boston, Kaiser Permanente Colorado, and Rand Corp-Veterans Administration in California.⁴

High-performing healthcare organisations and systems consistently demonstrate high levels of effective clinical leadership. This is known from numerous commissioned reports by governments⁵ and academic and transnational research^{6,7}.

The most notable examples are:

- US Veterans Affairs. New clinically focused leadership recognised that variations in quality and efficiency between facilities could be exploited to drive higher performance across the system. Patient satisfaction and clinical outcomes improved and the bureaucracy was transformed.
- Kaiser Colorado. Nominally a clinician-led organisation recognised it was struggling with declining clinical and financial performance and losing its best clinicians. It refocused leadership on patient outcome and experience which acted as a catalyst for a significant turnaround.

- UCLH in London had both low productivity and high mortality rates. The clinical director introduced a process with clinicians taking a greater leadership role in service planning and operations. This has led to sustained improvement in efficiency, clinical quality, and financial position.

Following from these examples NHS London and the NHS in Scotland have developed major new approaches to the systematic development of clinical leadership strongly linked to their health service reform agendas. These approaches are relatively new and outcome data are not available. Also none of these approaches is specific to primary care.

From all of the above, we were able to further refine our ideas about the importance of and best way to train people for clinical leadership.

What convinces senior health managers about the value of clinical leadership courses is that without active engagement of clinicians and clinical leadership, improved services for patients will not come about. Conversely, managers have seen huge quality improvement programs flounder because they were not led by clinicians.⁸

THE CHALLENGE OF CREATING LEADERSHIP CAPACITY AND CAPABILITY

For the Government's reform agenda to succeed, there needs to be a new relationship between the Department and those who will lead the reforms at the micro- and meso- levels of the system. It requires clinical leaders who understand and can interpret the new policies for their peers. More than that, clinical leaders need to understand how to bring about change. It follows that the large body of knowledge on how to be an effective clinical leader needs to be at their disposal along with peer support and mentoring. Training and support alone will not be enough. Further on in this report we cover the enablers and barriers which will need to be addressed by those providing the clinical leadership course and by the Department.

Research consistently shows that a third of health expenditure is wasted and that patients particularly those with chronic diseases receive half the care they should.⁹ For example, waste includes investigations ordered by GPs which are reordered on admission to hospital, or the absence of effort to obtain value for money in the choice of drugs prescribed. Patients who have diabetes have only a 50% chance of meeting the guidelines for any one of blood pressure, lipids, HbA1c, or depression.¹⁰ As health expenditure continues to take a higher proportion of GDP, the challenge is to get better performance out of the system.

Health care expenditure is committed by the flow from the GP's pen, or more accurately nowadays, the computer printing prescriptions, referral letters, and requests for investigation. It follows that the only way to improve that output is to engage those clinicians themselves in the pursuit of better clinical outcomes which generally reduce costs.¹¹

METHOD

Our overall aim was to identify priority actions for the Federal government to take to support the development of clinical leadership as a core element of Australia's primary care health system.

We reviewed a large number of reports and other documents, and conducted in-depth interviews with key leaders in health care in Australia and overseas for the previous APHCRI Stream 6 and Stream 10 projects that were concerned with organisational development in primary care in Australia related to chronic disease management.^{3, 4}

For this APCHRI Stream 16 project, we reviewed clinical leadership programs and other approaches to improving uptake of technology and clinical practice in Australia and overseas. We conducted over 20 in-depth interviews with Australia's leaders and practitioners in primary health care and policy. Most of those whom we interviewed were GP leaders already, covering

the main general practice organisations. We also interviewed State and Federal bureaucrats and academics.

A full listing of people interviewed is shown in Appendix 1.

RESULTS FROM INTERVIEWS WITH AUSTRALIAN HEALTHCARE LEADERS

WHAT PEOPLE ARE SAYING WE NEED

There is widespread support for a new clinical leadership program.

As one of the senior medical bureaucrats said:

It is the Holy Grail. Only clinical leadership works.

Why?

Money without direction is dangerous.

We need a more organised approach to primary care.

Cost and quality are two sides of the same coin.¹¹

The reform agenda is about bringing improved outcomes and efficiency leading to improved health and practice viability.

Clinical leadership needs to be stated in the primary care strategy.

There is another major reason. It is widely believed that the present system is not sustainable. The interviewees recognised that reform is on the way and they are expecting a shift in emphasis towards primary care, primary health care organisations, comprehensive primary health care clinics and improved chronic disease management – massive change. People working in primary care need to learn to lead beyond the local level and learn to build a new system of primary care. True leadership is going beyond the individual local problem for changing the system. There is widespread understanding of quality improvement techniques and the need to apply them.

Clinical leaders need to lead the change, not the bureaucrats.

You can't get benefits of change without leadership.

Change champions, who can move people, are going to be required at the level of the primary healthcare organisations or these larger clinics. They can accelerate the reform agenda. The benefits of change require leadership. There is a clear need for an agreed national approach related to government strategies. It is widely believed that there is no planned strategic approach for organisational change at the national level, that great things can be happening locally, but there are no mechanisms to spread them. There is no agreed national approach for implementation of strategy. In other words, people are looking for a more organised approach to primary care, run by clinicians who therefore need training. These change champions, the movers and shakers of primary care are people respected by their peers, thinking and reflective, people who will listen to them and follow them. They are the levers and the catalysts who are required to move towards a new model of primary care. Of course change management also needs to be aligned with rewards and incentives, perhaps based on payment for clinical outcomes. There needs to be a clear primary care strategy with an enunciated vision that captures the change champion's imagination.

Clinical leadership is not an easy role.

The hardest game in town is integrating the disintegrated

It is the opportunity to close the evidence-treatment gaps, implement guidelines, and use quality improvement techniques that will be the immediate appeal for change champions. They

will want to improve outcomes and efficiency that lead to improved health and practice viability. They will expect better tools to do the job including IT systems for chronic disease management, and they will want to see not only improved clinical performance but organisational change leading to improved organisational performance. They will want to spread good practice among their networks, including behaviour changes that lead to better use of data to achieve clinical outcomes.

We have to think beyond working through problems at local level

One interviewee summarised a commonly held view that superclinics are a very small part of new healthcare organisations. No one was quite clear what a comprehensive primary health care centre was. Three respondents who work in superclinics strongly favoured clinical leadership and thought it a pre-investment which would precede superclinics so that there was greater likelihood of new models of care.

It was frequently said that change does not happen without support and people cannot manage the change for themselves. They see the clinical leaders helping them bring about change and, “giving an easy ride to the future”. In other words, they know that better leadership will deliver better outcomes.

EXPLORATION OF EXISTING DEVELOPMENT OPPORTUNITY

IT CAN BUILD ON EXISTING STRUCTURES

The Department of Health and Ageing told us that they develop policies and programs. The implementation including the change management is the role of others to undertake using the funding from the Department. A successful example of this was the computerisation of general practice in 1999 – the uptake went from 15% to 85% in 18 months. Professor Michael Kidd who led the project had a very deliberate change management plan including clinical focus, solutions for confidentiality, consumer engagement, clinical training and support, champions, common IT architecture, good communications, evaluation in-built and funded. IT facilitators were funded in each Division.

The improved uptake of immunisation was cited as another example. A more relevant example was the program called Building on Quality over ten years ago. This program created a notable cohort of GP leaders who are still active in the system and have generated improvements like the Hunter Urban Out of Hours Service, and Adelaide West's Practice Health Atlas.

These examples are seen as the exception rather than the rule.

The widely held view is that there is no systematic support for change and often minimal consultation with GPs. The approach is ad hoc and fragmented. A policy is little more than changes in MBS item numbers such as SIP and PIP.

Australian General Practice Network (AGPN), the State based organisations, and the Divisions themselves, are seen as the implementation arm of policy. Only a few divisions are thought to be able to manage change effectively. Here lies the dilemma for the Department if it intends major reform of primary care.

The most commonly mentioned successful existing structure is the Improvement Foundation's Australian Primary Care Collaboratives. Their success is attributed to the use of measurement, grass roots support, voluntary change, peer comparison, and practice level strategic change. A crucial instrument has been the PEN tool to extract data from practice computers. The Improvement Foundation also runs QuISP¹² which is a clinical leadership program; the same program in the UK feeds into a Masters program. Another federally funded program developing a small number of leaders is the National Institute of Clinical Studies (NICS) fellowships.¹³ It provides one year full-time or two year part-time highly resourced support for about ten Fellows to undertake projects aimed at narrowing the evidence-practice gap. Useful lessons for training clinical leaders can be obtained from NICS. A number of organisations including NICS and State

Health Departments mentioned using IHI breakthrough series. In the case of NICS, a heart failure program was taken up by 50% of Divisions through their National Prescribing Service pharmacist academic detailing.

The State Health Departments in NSW, Queensland, SA and WA have clinical leadership programs. Queensland has trained its top 600 executives using a highly resourced external program that included on-going coaching. A miscellany of other existing programs was mentioned by interviewees in reply to the questions about what else contributed to change management for new technology and clinical practice. Their replies included the coordinated care trials, national service improvement frameworks, "A TEAM" model of the Asthma Foundation, the National Prescribing Service, KPMG clinical leadership, Australian Graduate School of Management, University of New England Nurse Leadership and Development Program, AMA clinical leadership program, Australian Institute of Company Directors, Australian Rural Leadership Foundation national leadership program.

Most people saw much of this miscellaneous list as ad hoc and they did not see it as a comprehensive systematic approach to organisational development, nor could they identify much clinical leadership training within most of them.

Other than QuISP, the only examples of clinical leadership programs in primary care are those run by RACGP¹⁴ over two days and the one run by General Practice South Australia.

The sum of these activities in primary care has led to general practitioners recognising the importance of organisations and teams in improving clinical outcomes. They have also recognised what good leadership can do when properly funded and supported, eg, the rapid uptake of computerisation. The ground is well prepared for a clinical leadership program aimed at 30 to 40 year olds who will lead a generational change in the delivery of primary care.

EXPLORATION OF EFFECTIVE DEVELOPMENT PRACTICE

THE FEATURES OF A SUCCESSFUL PROGRAM

There was a strong emphasis on the need to have an experiential course linked to participants' experiences at work and the associated problems. Although interviewees recognised that it needed to be grounded in some theory, there was a strong desire to use real problems and case histories for much of the learning with the theory taught subsequently to provide framework explanation. A stepwise course progressing from Grad Cert to Masters program was thought to be the best option by most people, although there were some that did not favour a university option. A majority supported the idea of a course run by APHCRI at Australian National University (ANU).

Interviewees were asked about the relative merits of face-to-face training versus the use of distance learning. People favoured the blended approach of both. A combination of two days face-to-face four times a year with web based and tele/video conference activities between them comprises the blend.

The advantages of face-to-face were seen as

- Forming relationships that led to improved communication and networks
- Setting up one-to-one connections for peer support
- Developing learning sets
- Mind-emptying in preparation for receiving new ideas - the importance of leaving practice concerns behind,
- Being able to bring and work on real problems
- Being able to interact with clinical leaders who present on the program
- Time away and the chance to lift your head up to scan the horizon

- Cross-fertilisation and social exchange
- Time away from patients
- Excitement and new challenges

It was generally believed that face-to-face learning built confidence by learning through shared group experience and gives opportunities for small group learning.

Peer support lasts beyond the course. That might be its most important outcome.

If APHCRI at ANU were to put the course together, it was generally felt that they should not use pre-existing modules, but rather use modules that were designed for this course. To ensure that their content reflects the needs of the sector, it was thought that APHCRI ANU should form a course development group. Suggested participants include: consumers, AGPN, RACGP, ACRRM, Improvement Foundation Australia, RCNA, medical educators from regional training providers, allied health professional bodies, AMA, APMA, APNA, plus experts from Australia and overseas.

A strong minority view felt that RACGP and AGPN should be excluded because they might promote conflicting agendas.

The course would need to be accredited by ACRRM and RACGP for continuing professional development points. The experience from the Building on Quality program and other clinical leadership programs is that an international study tour to UK or the US is invaluable.

Participants want knowledgeable and experienced individuals to contribute to the teaching rather than didactic ivory-tower academics. Most people saw this as a generic leadership skills program that would suit anyone in the primary health team. It was thought that CEOs and Chairs or the Regional Training Providers should be eligible.

The Masters qualification would be Masters in Clinical Leadership. MBA was thought to be a debased currency. A number of interviewees commented that adding letters after the name was a strong incentive to take a leadership program. A minority view felt that an academic qualification was unimportant.

Entry would be by open advertisement and an application selection process. Credit would be given for prior learning.

KEY TOPIC AREAS AND DEVELOPMENT APPROACHES

The key topic areas identified by those interviewed for clinical leadership programs are:

- Leadership theory and practice
- Organisational behaviour and organisational change
- Systems thinking
- Professionalism and ethics
- Quality improvement
- Team development and group work
- Governance
- Change management
- Performance management

Development approaches identified by those interviewed included:

- Problem based learning

- Learning by doing
- Clinicians as mentors
- Sharing stories
- Theory linked to case study
- Face-to-face and on-line
- Inspirational speakers and examples
- Case studies
- Overseas study visit

IDENTIFYING BARRIERS

The NHS London report identified four underpinning barriers to the development of effective clinical leadership.⁵

1. Clinicians have limited exposure to leadership experiences.
2. As a group, clinicians are not selected on the basis of either leadership skill or potential.
3. Leadership development for clinicians is not systematically encouraged.
4. Much of the leadership training given to clinicians outside their core curriculum is seen as low value.

From the interviews we conducted for this APHCRI Stream 16 project, the main barriers identified were:

1. Clinical leadership is not perceived by individual clinicians to be of high value to the system overall. As a result of this, time, financial support, and access to high quality development programs are not consistently available.
2. GPs not seen as responsible for population health on a geographic basis.
3. Perceived lack of organisational support.
4. Lack of acknowledged role models.
5. Availability of custom-designed practice focused development.

It follows that in developing primary healthcare organisations these barriers need to be overcome so that the best candidates are attracted to positions of clinical leadership

RECOMMENDATIONS

The NHS London report, in looking at leadership-rich environments, recognised that the best had leadership development programs which were clear about what sort of leadership they were trying to develop and why, built cache around the leadership selection process, tailored interventions to individuals' needs through a focus on practical application of learning, and provided ongoing support for developing leaders.⁵

Based on the results of our review of existing programs, interviews and inquiry into international practice, we would recommend:

1. The establishment of a national clinical leadership development program focused on primary care, and tied to the achievement of service change and improvement. It is expected that there would be 60 to 80 participants per year for five years.

2. Clinical leadership be clearly identified as a fully resourced initiative within the primary care strategy for there to be belief that there will be effective implementation.
3. That APHCRI which enjoys wide support from the professional stakeholder group put this course together
4. That clinical leadership should be open for the whole sector not simply for superclinics or comprehensive primary care centres.
5. Participants should neither pay for nor be paid for completion of the program. The Department of Health and Ageing is expected to cover the cost of university fees, travel, locums, and accommodation.
6. It was universally believed that the course should be voluntary.

DEVELOPMENT OF A PREFERRED OPTION

WHAT IS THE DIFFERENCE WE ARE TRYING TO MAKE?

Australia faces major challenges in relation to the delivery of effective health care that will control costs, ensure quality and remain progressive and open to innovative practice. The primary care reform agenda has its roots in the need to close the evidence/practice and access gaps, linked to the need to drive change that makes a positive difference for patients, delivers efficiency and value for money and is supported by effective corporate and clinical governance.

The evidence from Australia and other countries where primary care reform is an established part of the agenda is that the reform policies impact if they are clinically rather than managerially led, and the health system needs to give time, energy and resource to developing the capacity and capability of clinical leaders to take on this role. The success of services such as the Veterans Administration in the USA, where major change in the management of chronic disease services has been achieved, is an example that is widely recognised as providing an effective model of clinically led service change and improvement.⁵

It has been argued that future clinical leaders would need to combine “leadership, scholarship and fellowship”.¹⁵ This program seeks to develop these three elements through:

- Exploring and building leadership capacity
- Using and further developing sound academic teaching
- Learning, research and evaluation
- Ensuring that the design of the program actively supports shared learning
- The development of challenge and support based professional networks

The approach proposed in this paper offers a program design that is based on research and practice into what will effectively develop capacity, and grow a cadre of clinical leaders who can take on this challenge. It takes into account the findings of the research into needs and desires of clinical leaders in primary care and research on effective learning and development practice. There is a strong similarity between the viewpoint expressed by our key informants in their interviews and what we would have derived from reviewing experience of clinical leadership programs elsewhere.

UNDERPINNING APPROACH TO LEADERSHIP

In developing a leadership program, it has been critical to make some choices about the model of leadership which the program will develop. Given the challenges outlined above, and the findings of the research detailed in this report, it is clear that we are looking at a socially constructed model of leadership which is inherently relational. That is a model which is about creating:

- Meaning and direction
- Enabling groups and individuals to act and keep focus on the outcomes developing effective processes that are responsive to their context
- Effective engagement
- Accountability

To develop this approach to leadership the program itself needs to use methodologies that build skill and capability through the learning processes, that is, learning by doing, rather than learning by reading/studying and then trying to apply. Rooted in practice and group processes experiential learning is the key for successful individual development, by enabling individuals to develop their relational leadership skills. The program content further develops their understanding of why this matters and the impact it can have.

APPROACH TO PROGRAM DESIGN

Evaluation of outcomes is the starting point for the design of this program. By defining at the beginning the outcomes that are desired, the program includes formative and summative evaluation which will support on-going development, enabling the program providers and participants to review and improve the content and learning/delivery. For this to work effectively, program providers will need to work with policy makers to define what successful reform of primary care will look like in terms of outcomes for:

- Patients
- Clinicians
- Clinical leaders
- Service Governance bodies and
- Policy makers

These outcomes become the core objectives for the program, rather than traditional learning outcomes, and the development of clinical leadership becomes the process by which these outcomes are achieved. This approach to setting core objectives also ensures that the program itself becomes rooted in practice, with academic, policy and research input providing elements of the learning and personal development that will enable clinicians to design, lead and deliver change proactively.

DESIGN CHALLENGES

The biggest challenge for any learning program that has a service development purpose is to ensure that learning is transferred into practice. This has been addressed in a number of ways in recent years, from asking program participants to undertake project work, to setting written assignments that require participants to apply learning to a practical example and produce a reflective analysis.

The design approach of this program is to start from the basis of practice, i.e. participants will be working on their “day job” of delivering reform of primary care and that the learning modules will provide them with different elements of knowledge, skill and experience to expand their thinking and practice and thereby build their capacity and capability to deliver major change.

Underpinning this approach will be the learning methodologies of blended learning which will start with developing action learning and reflective practice skills, and then adding the intellectual thinking, critical analysis and research approaches that will support academic accreditation. The program will combine face-to-face learning, with e-enabled and on-line approaches including moderated/facilitated action learning using remote technologies, blogs, e-based discussion forums and the support of a wide range of on-line learning materials.

As participants will be working on different elements of primary care reform and will also be bringing different levels of knowledge, skill and experience to the program it is essential that the design has an element of flexibility which enables individuals to tailor at least some part of the overall program content to their individual needs. This leads the design towards having a core spine, supported by choice options which will add richness and diversity, but also require effective co-ordination and support.

A further challenge for this program is the geographic spread of potential participants and the need to contain costs. Balanced against this is the evidence on effective blended learning approaches, which makes it clear that for remote web-enabled learning to be really successful it needs to start with and have an on-going program of core elements that are delivered through face-to-face learning. This is particularly important where the development of effective learning networks which will last beyond the life of the program is one of the objectives of the overall program provision.

SELECTION

One of the issues raised by interviewees was the exclusivity or cachet that would be attached to any program. Whilst it is highly desirable to develop this and ultimately for applications to the program to exceed number of available places, this is unlikely to be the case for the first cohort, however, clear criteria for selection should still be supplied and a process for selection agreed.

As this will be an accredited program the issue of Accredited Prior Learning may need to be addressed, to ensure that all participants are able to fulfill the criteria for a post graduate qualification. However some other criteria should also be considered including whether or not the individual is in a position to act as a change leader/champion and has the support of their local system to both learn about and effect major service change.

ACCREDITATION AND PROGRESSION

A further core challenge is to develop a program that has clear accreditation options within it. Whilst a non-accredited program is an option, the overwhelming view of those interviewed appears to be that the ability to achieve accreditation, and on a cumulative basis, would be a key selling point. On this basis it is suggested that the core spine of the program should provide a minimum of 24 units, which would lead to a Certificate in Clinical Leadership at the end of year one. The addition of further modules would allow individuals to build sufficient credits for higher awards from Diploma through to Masters. During the second year that would be options for deeper learning on existing modules, or the option to develop, implement and review a major quality improvement program, with supporting analysis and a formal management report. This approach would enable participants to take advantage of the wide range of modules available through on-line resources and to demonstrate learning through practice-based application and review.

In Year One assessment would be based on a combination of:

- Group work participation – evidenced through learning set activity, e-discussion forums and residential module based group work (30%).
- Reflective learning – evidenced by production of a personal learning plan, and a reflective journal or blog (30%).
- Production of at least two management reports during the year related to progress on key change issues which are within the remit of the individual participant, and which are supported by reflection on theory and practice (40%).

ENHANCING EXPERIENCE

One of the elements of the program should be to enhance learning by inviting speakers from those outside the Australian health care system. This could mean clinical leaders from other health systems, inspired leaders/thinkers from other walks of life, and academics in the leadership field from outside Australia. It is suggested that a combination of approaches should be used:

- At each residential module there should be at least one “inspirational” speaker who will stimulate thinking and debate on the key topics for that module.
- As part of the on-line/e-enabled learning environment pod casts of external inspirational leaders and experts should be available.
- Webinars should become part of the learning set approach to further developing and sharing learning.

ENSURING EFFECTIVE LEARNING - COHORT SIZE

It is suggested that cohorts of 60 should be recruited for each intake on the program. Each cohort would contain 5 to 6 learning sets of 10-12 people. The course could be expanded further but a judgement would need to be made on whether increasing the size of the cohort diminishes the quality of the learning experience. A cohort of 60 ensures good cross fertilisation and networking at residential modules and also opens the opportunity to work with different groups over the length of the program.

The learning sets should involve 10 – 12 individuals and should be interest rather than geography based. This does mean that working in an e-enabled environment will be critical. Learning sets should use video or tele-conferencing, supported by web based discussion forums. This will mean that the facilitators for such sets will need to have expertise in facilitating and moderating in this technology based environment.

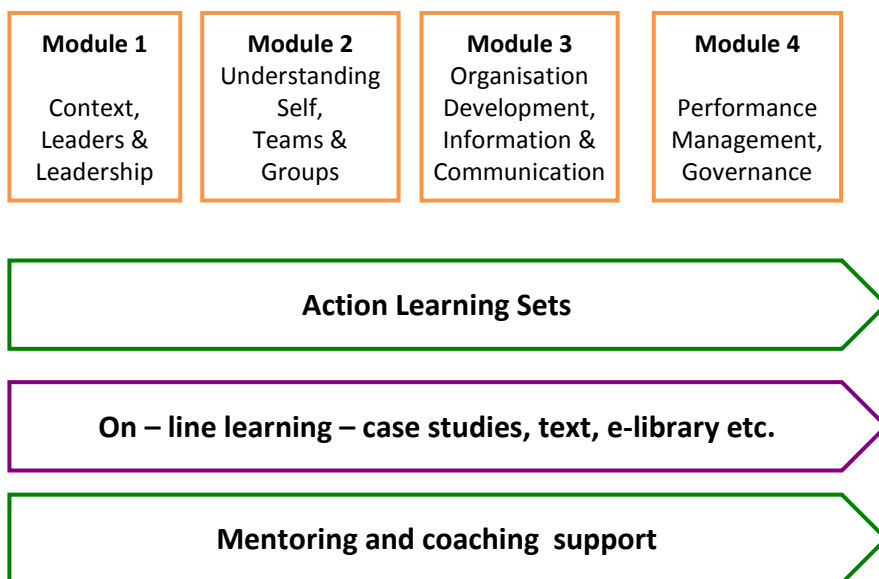
CORE DESIGN ELEMENTS

Given the challenges outlined above, and the growing evidence from research and program evaluation into what makes leadership development programs effective, such as the work undertaken by the Centre for Creative Leadership, this program incorporates certain core elements.

- Face-to-Face learning through 4 residential modules. The basic approach of these sessions will be to use case studies, examples of work from participants and live examples from comparable systems backed by theory.
- E-enabled, video-conference or telephone conference facilitated action learning sets. Learning sets are designed to enable participants to work on their practice based challenges, to enable them to apply the learning from the core face-to-face modules to their practice and to learn from one another through a well established facilitated support and challenge process. These learning sets will form the basis for future networks of support and challenge of clinical leaders. They should continue to connect with each other beyond the life of the program.
- On-line learning, with a combination of theoretical, research and practice/case study material. On line learning should be provided as library of resource that participants can select from. This should include pod casts, case studies in written, audio and video/dvd format, core texts and best practice examples.
- Tutor support on an individual basis through e-enabled/telephone coaching. Tutors/learning set facilitators will be available to give advice and support to participants on issues of learning and application of learning to practice.
- Option for mentoring at a local level. Participants on the first cohort will be encouraged to seek appropriate mentors at local level, to give a further level of support and challenge. Advice will be offered on “what to look for in a mentor” and “the mentoring process – a good practice guide”. For the second cohort and beyond it is anticipated that participants who have completed the first year of the program will take on the role of mentor for new participants, thereby expanding the network of connections and support.
- On-going evaluation and review through questionnaire, semi structured interview and personal reflection. Continuous evaluation is a core element of the program, so that it

mirrors the approach to continuous learning, change and review that the program itself is supporting. It will also be important to incorporate new case studies from participants as the program develops beyond the first cohort.

The core program will be designed to run over a 12 month period, with four residential modules of 2/3 days at quarterly intervals, interspersed with at least 2 action learning set discussions between each residential module. Learning sets will be established at the first residential module, linking people on an issue rather than geographic basis and offering the opportunity to opt for either e-enabled or video conference based learning set sessions.



THE MODULE DESIGN AND INDICATIVE CORE CURRICULUM

The program will be made up of 8 learning modules, the core of which will be delivered through the residential elements with the expectation that participants will then supplement the core input with reading, reflection and application supported by a resource of on-line materials that combines articles, research text, case studies, abstracts etc.

This individual learning will be tailored around the practice challenges each individual is working with, and will be supported through the action learning sets and on-line/telephone coaching.

The order of the core modules has been carefully considered and is based on evidence of what works gathered from evaluation data on different leadership programs.

RESIDENTIAL MODULE 1

(a) Context

This first module will bring together input on the policy and practice context of primary care reform and the challenges of achieving sustainable system change with input that uses case studies to explore core concepts including:

- Public Value¹⁶
- The new Professionalism – discussion and exploration of implications for clinical leadership.
- Systems Thinking¹⁷
- Complex adaptive challenge and technical challenge¹⁸

- Introduction to theories of change.
- Introduction to place based leadership development¹⁹

(b) Leaders and Leadership

This module will explore concepts of the leader and leadership with an emphasis on work that focuses on the public sector and uses case studies, recent research, writing and thinking. Core elements will include:

- Action Centred Leadership²⁰
- Adaptive leadership¹⁸
- Transformational leadership²¹
- Arts of leadership²²
- Collective and collaborative leadership²³
- Servant Leadership²⁴
- Good to Great in the public services²⁵

RESIDENTIAL MODULE 2

(c) Understanding Self

Participants will be expected to complete a 360 degree evaluation, it is suggested that the instrument developed by Beverly Alimo-Metcalf would be suitable, and this could be further supplemented by Myers-Briggs and Belbin team types. At this stage, it may also be useful for participants to undertake a learning styles review. Core elements of this part of the module will include feedback and group discussion, and some work on:

- Self as an instrument of change
- Facilitation, challenge and support – skill development
- Personal learning plans and approaches
- Personal ethics and values
- Further reflection on self and the new professionalism.

(d) Teams and Groups

This element will focus on learning about teams and groups, what makes them work effectively or not, and what this means for building notions of collective and collaborative leadership to drive and support effective change. Case studies and discussion on participant experience and reflection will enable the group to explore a range of issues and approaches. Core elements of the module would include:

- Belbin on team types
- Group functioning²⁶
- Developing effective groups²⁷
- Collaborative advantage²³
- Partnership working²³
- Dialogue²⁹

RESIDENTIAL MODULE 3

(e) Achieving Effective Organisational Change

This part of the module will focus on learning and practice in organisational development and change. It will be designed to look at technical change, complex adaptive change and the people issues associated with achieving successful change. Case studies and participants own

change challenges will be used as the basic material through which core concepts and approaches can be reviewed and evaluated. Core elements will include:

- Six Sigma and process redesign approaches
- LEAN and rapid improvement techniques
- Collaborative and health improvement systems³⁰
- Quality improvement processes e.g. European Foundation of Quality Management models and approach (www.efqm.org)
- Complex adaptive change
- Organisation Development³¹
- Large scale change approaches including open space, future search etc³²
- People and change, transition management etc³³

(f) Information, communication and ICT

This part of the module will be designed to give participants some case studies on information systems, communication challenges and use of ICT. One key focus will be on theories of communication and employee participation. Key inputs will include work on:

- Information systems to support rapid cycle change
- Data capture and data analysis
- Communication systems
- Engagement and participation processes. (CIPD, Improvement and Development Agency Institute of Employee Studies etc)

RESIDENTIAL MODULE 4

(g) Performance Management

These final two modules will focus on both individual and organisational issues. In the performance management part of the module our expectation would be that participants would bring their experience of successful and less successful performance management systems to the program and use them to explore the following issues:

- Personal performance management review
- Professional performance management and peer review systems
- Organisational performance management – metrics, qualitative systems
- Service reviews
- Patient engagement and participation, expert patient approaches

(h) Governance and Accountability

This final part of the core program will again look at the personal and organisation issues involved in Governance and Accountability as experienced by participants and through case study examples from other health systems. This practically based approach will include issues such as professional ethics, as well as corporate issues of transparency and integrity.

- Standards in public life (Government and Audit Commission guidance)
- Clinical governance in primary care³⁴
- Corporate Governance³⁵
- Audit and risk

ON-LINE RESOURCES

Examples of effective on-line learning resources are now very numerous, including those which are university based and those from a more practical/hands on and pragmatic perspective. The combination of both such approaches can work most effectively, supporting the reflective practitioner to both enhance their learning and improve their practice.

Examples of this joint approach have been development with other programs such as the Leadership for Mental Health Services program in Scotland which combined the NHS E-Library with goodpractice.net .This latter organisation provides abstracts of articles and books, and case studies of good practice on a wide range of issues. It is possible to take a licence with them which will result in them building a resource that matches the core elements of the development program and which is continuously updated with new materials being added on a regular basis.

APPROACH TO CAPACITY BUILDING

The core requirement for this program is to not only build knowledge, skills, and capability in individuals but to cumulatively build capacity within the whole primary care system, to lead, review and continuously improve system and service change. It is also essential that this capacity building creates more efficiency in the system, so that continuous improvement and continuous professional development are part of the expected drive for efficiency and effectiveness.

The approach suggested in this paper is based on experience of successful capacity building from other areas such as the major Social Care Leadership programs in Scotland, private sector experiences such as those of Cathay Pacific and other examples of good and innovative practice.

The capacity building approach supports some of the essential “learning into practice and practice into learning” elements of the program.

MENTORING

For the first cohort on the program, local mentors will need to be drawn from the wider health system, which will also help to build support for the program and its objectives with a wider audience.

It is envisaged that the participants from cohort 1 and the successively from future cohorts will then take on the mentoring role for future participants. This will further enhance the learning for the mentors and add value for the current participants.

LEARNING SETS INTO LEADERSHIP COMMUNITIES

The program places emphasis on the use of learning sets, with each learning set meeting (remotely or in person) at least twice between each residential module.

These sets form the base for on-going leadership communities. Experience of running such communities shows that if they are supported by an administrator/community facilitator they can become very effective continuous learning and improvement centres. Coming together 2-3 times a year, to share learning from on-going change programs, to bring in speakers from other systems or to debate major challenges and policy shifts, the communities provide a means of meeting the on-going learning needs in CPD terms, but also ensure that the learning/practice cycle is embedded and supported.

LEARNING SET FACILITATION

For the first cohort, the facilitators would need to be externally provided. Facilitation provides a major learning and development opportunity. Experience from other systems has demonstrated that developing this capacity has been useful in building internal support for major change initiatives.

CASE STUDY DEVELOPMENT

For the first cohort, case studies of effective leadership and change will need to be developed, using international as well as national experience. For all future cohorts case studies should be developed from the work of participants on the program, thereby developing a learning resource for both all the clinical leaders on the program and for the wider health system.

REFLECTIVE JOURNALS/BLOGS

A key part of supporting clinicians and other leaders to become reflective practitioners and learners comes from the practice of writing and sharing learning. Many professional development programs now use personal learning journals, but these can become tedious for participants and difficult in terms of sharing and review/assessment. One new development has been the use of blogs, where individuals can quickly capture some reflective thinking and share this with their learning set colleagues. The moderator can review what has been written, pick up on key issues which will help group learning and also provide some feedback to the individual.

EVALUATION AND REVIEW

Throughout the program there will be a process of evaluation and review, built on feedback from participants, module directors, and learning set facilitators.

At the end of the first year there should also be an impact assessment, linking back to the objectives set at the beginning of the program and seeking feedback from line managers, peer groups etc.

It is essential that the evaluation framework is established at the beginning of the program and is built into the whole process, so that formative and summative reviews can be collected, analysed and shared with participants and providers.

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APPENDIX 1 - LIST OF KEY INFORMANTS INTERVIEWED

NAME	POSITION	ORGANISATION
Mr Robert Wells	Director Menzies Centre for Health Policy, Director Australian Primary Health Care Research Institute	Australian National University College of Medicine, Biology and the Environment
Prof Chris Brook	Executive Director	Rural and Regional Health and Aged Care Services, Department of Human Services, Victoria
Dr Stephen Clark	CEO	Australian General Practice Accreditation Ltd
Dr John Wakefield	Senior Director	Queensland Health Patient Safety Centre Reform & Development Unit
Prof Michael Kidd	Executive Dean	Faculty of Health Sciences, Flinders University
	Past President	Royal Australian College of General Practitioners
Dr Sue Phillips	Interim Executive Director	National Institute of Clinical Studies, National Health and Medical Research Council
Ms Kylie Mayo	Manager Clinical Networks & Service Development	Programs Branch, Department of Human Services, Victoria
Prof Claire Jackson	Professor of General Practice and Primary Health Care and Head of Discipline	Discipline of General Practice, School of Medicine, University of Queensland
Dr John Aloizos	Chair and Non-Executive Director	Inala Primary Care Ltd
	Chair and Non-Executive Director	Balance! Health care Pty Ltd
	Non-Executive Director	Australian General Practice Accreditation Ltd
	Non-Executive Director	Quality in Practice Pty Ltd

AUSTRALIAN PRIMARY HEALTH CARE RESEARCH INSTITUTE

NAME	POSITION	ORGANISATION
Dr Dale Ford	Principal Clinical Advisor	Improvement Foundation (Australia)
Dr Tony Lembke	Board Director	Australian General Practice Network
	Chair	Northern Rivers General Practice Network
	Clinical Director	Australian Primary Care Collaboratives
Assoc Prof Dennis Pashen	Director	Mount Isa Centre for Remote Health
	President	Australian College of Rural and Remote Medicine
Dr Lynne Davies	Chair, CHD Expert Reference Panel	Australian Primary Care Collaboratives Program
	Director on Board	Northern Rivers GP Network
Dr Richard Bills	Victorian Clinical Chair	Improvement Foundation (Australia)
	Executive Medical Officer	Central Highlands GP Network
Dr Simon Towler	Chief Medical Officer	Department of Health, WA
Assoc Prof Ron Tomlins	Chair	RACGP National Standing Committee on Quality Care
Prof John Marley	Professor	Faculty of Health Sciences, The University of Queensland
Dr Emil Djakic	Board Member	Australian General Practice Network
Liz Forman Vicki Murphy Kerry Burden Rosemary Knight Hitendra Gilhotra		Primary and Ambulatory Care Division, Department of Health and Ageing
Dr Shiong Tan	Commissioner	Australian Commission for Safety and Quality in Healthcare

APPENDIX 2 - RESEARCH TEAM

Professor James Dunbar (MD, FRCPEdin, FRCGP, FRACGP, FFPHM, FACRRM) is the inaugural Director of the Greater Green Triangle University Department of Rural Health, Flinders and Deakin Universities. His main research interests are in diabetes, heart disease and depression from prevention through to better management in primary care. He also has a long standing interest in the contribution of organisational development to improve performance in primary care. In his former post of Medical Director of Borders Primary Care NHS Trust in Scotland, he had considerable experience of organisational development techniques including clinical leadership programs. From his work during that period he had a strong interest in quality improvement in health care, for which he won the Golden Phoenix Award – the primary award for improvement in health care in the UK.

Professor Prasuna Reddy is Chair of Rural Mental Health Flinders University, and Director of Research, GGT University Department of Rural Health. She is a practising health and organisational psychologist and her areas of expertise are applied psychology in health systems, and professional ethics. Professor Reddy is responsible for managing a number of grants held by the Department which include NHMRC, ARC and Carrick grants in the areas of diabetes prevention, clinical links between depression, heart disease and diabetes, management of chronic disease, quality and safety in organisational environments, and interprofessional ethics. She has given numerous invited presentations in Australia and overseas at universities, conferences and community health arenas and her publications include several books, book chapters, refereed journal articles and contracted reports. Professor Reddy was also co-ordinator of the Ethics Law and Professional Development program at Deakin University School of Medicine until mid 2009, and a member of the Human Research Ethics Committee of the Department of Human Services Victoria. She is currently Director of Training for the Life! Taking action on diabetes program, a joint initiative of the Victorian Government and Diabetes Australia – Victoria, and a board member of Antares humanitarian aid organisation.

Professor Zoë van Zwanenberg Chief Executive, Zwan Consulting Ltd, Edinburgh, United Kingdom. She is also Project Coordinator for the Centre for Confidence and Well-Being. Zoë has held several management positions, specialising in human resources and people development, including Chief Executive of the Scottish Leadership Foundation, Head of Development at the Strategic Change Unit for the NHS in Scotland and Non-executive Director for the Centre for Confidence and Wellbeing. Her publications on issues of leadership include training and development for leaders in mental health services and leadership in social care, and leadership across public services.

APPENDIX 3 - INTERVIEW BRIEFING

We are conducting a study for APHCRI based at ANU in Canberra.

The purpose is to determine the usefulness of clinical leadership and team development training in the Australian primary care system, and to assess whether additional clinical leadership or team development programs are required and how they might be administered.

We have already undertaken a systematic review and visited key informants in Canada, Netherlands, New Zealand, UK and USA. This has given us a picture of clinical leadership and team development activity overseas. Our key findings were:

- Efforts to change clinical practice by influencing individuals have proved ineffective unless the organisation within which they work is ready to change.
- Performance in healthcare organisations is inextricably linked to leadership, culture, climate, and collaboration which can be improved by organisational development.
- Organisational development is particularly effective in improving performance in chronic disease management, quality and safety.

The purpose of this interview is to find out what you know about models for change management in primary care. The two areas that we would like to focus on are change management in relation to technology, and clinical practice.

Our systematic review of organisational development convinced us of the close links between leadership, culture, collaboration, teamwork, and improved health outcomes. Therefore, we may move backwards and forwards between these concepts during our discussion with you.

You may be aware that the National Health and Hospital Reform Commission has proposed supporting the health workforce by improving workplace culture, management and leadership skills at all levels of the system, and has invited feedback on mechanisms to achieve this. The Reform Commission has also recommended implementing models that formally involve all health professionals in guiding the future directions of health reform, and places value on their ongoing commitment to delivery and care.

Question 1.

a. Are you aware of any change management programs for the introduction of technology and clinical practice reforms at:

- organisational,
- regional, or
- national levels?

b. What are the current models for the delivery of change management in primary care in relation to:

- technology, and
- clinical practice reforms?

c. Are there case studies available to support these models?

d. To what extent have these been successful?

e. What are their characteristics in achieving positive change?

Question 2.

Clinical leadership programs in other countries come in various forms and mostly lead to a university qualification of a Masters degree or less. Frequently there is recognition of prior learning, e.g., participation in Collaboratives. Educational approaches vary from distance learning through periodic attendance at didactic teaching assessed by essays, to programs that largely use group discussion of case studies, or work on participants' own change management programs in real time. In some programs, theory is added after problem based work.

Real teams working on real problems in real time.

- a. If a policy imperative was to initiate clinical leadership and team development for superclinics or comprehensive primary health care centres, how would you rate the effectiveness of these various educational approaches?
- b. Would there be merit in bringing people together, e.g., through APHCRI/ANU, for this training?
- c. How long should this course be in face-to-face teaching hours or time on line?
- d. What level of academic recognition should be given for such a course?
- e. What topic areas should be covered if the aim is to produce clinical leaders for superclinics or comprehensive primary health care centres?
- f. What incentives and rewards should there be for participants?
- g. How should they be funded to participate?
- h. Should this training be voluntary or compulsory?
- i. If APHCRI were the administering body, what other organisations should contribute to:
 - curriculum development,
 - curriculum delivery, and
 - governance.

Question 3.

- a. At this stage, could you sum up your thinking on what and how the program would work?
- b. What benefits would you expect for performance of the recipients, e.g., the superclinics.
- c. What enablers and barriers would you anticipate?
- d. How would you manage them?

Question 4.

The National Health and Hospital Reform Commission has presented the government with a large agenda which will require prioritisation. Assuming that clinical leadership and team development became widely available, say for superclinics or national primary healthcare centres, how high a priority would you give clinical leadership training and team development, on a score of 1 to 5, with 1 being the highest priority.

Question 5.

- a. In the first instance, do you think clinical leadership training should be restricted to general practitioners alone or should it be open to other disciplines? If so, which disciplines?
- b. Are there specific issues for different professional groups that need to be addressed and if so, what?

Question 6.

Are there any other points you would like to make?

If any further thoughts occur to you, between now and the end of November when we will be reporting to APHCRI, please contact us.

APPENDIX 4 - ACRONYMS

ACRRM	Australian College of Rural and Remote Medicine
AGPN	Australian General Practice Network
AMA	Australian Medical Association
ANU	Australian National University
APCC	Australian Primary Care Collaboratives
APHCRI	Australian Primary Health Care Research Institute
APMA	Australian Practices Managers Association
APNA	Australian Practice Nurses Association
IHI	Institute for Healthcare Improvement, Boston Massachusetts
NICS	National Institute of Clinical Studies
RACGP	Royal Australian College of General Practitioners
RCNA	Royal College of Nursing Australia