PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	"At the grass roots level it's about sitting down and talking": Exploring quality improvement through case studies with high-improving Aboriginal and Torres Strait Islander primary health care services
AUTHORS	Larkins, Sarah; Carlisle, Karen; Turner, Nalita; Taylor, Judy; Copley, Kerry; Cooney, Sinon; Wright, Roderick; Matthews, Veronica; Thompson, Sandra; Bailie, Ross

VERSION 1 – REVIEW

REVIEWER	Elizabeth Lynch University of Adelaide
REVIEW RETURNED	17-Dec-2018

GENERAL COMMENTS	Thank you for the opportunity to review this interesting article about unpacking successful quality improvement teams working in Aboriginal and Torres Strait Islander primary health care services. I found the manuscript to be well written, clear and very easy to understand. I have only minor points I really like the title! Table 1: spell out abbreviations eg DMS in footnotes. Row 3 "support from Menzies" likely to require extra explanation for readers outside Australia P12 Lines 198-204 writing swaps to first person (having been in 3rd person previously) which is a bit distracting P22 Lines 454-458 seemed repetitive - have presented this info earlier in Results Theme "Understanding and responding to historical and cultural context" - I found this section really interesting and illustrated clearly and elegantly with text and quotes. I could not see how historical context came through here though - it was clearly important to work within an indigenous cultural framework, but throughout text, it is written about "historical context" as well, which I did not grasp through the information presented both in text and quotes. So I would suggest authors consider presenting something about the history of ?establishment of dedicated indigenous healthcare services, or history of some element of indigenous healthcare (or something else relevant to historical context) or consider re-wording this theme to "Understanding and responding to cultural context" P23 Line 483-487 - consider moving this up to start of this section P25 Line 518-9: the end of this sentence is really awkward, which is a contrast to how smooth/easy-to-read the rest of the text is P25 Lines 527-531: it was not clear to me how this example shows how the community is driving healthcare (2nd example much

	clearer to me) - seemed there were community members on a committee along with other stakeholders - a bit more description here would be helpful Discussion I think could be improved by condensing - I see author guidelines recommend (but don't insist on) 5 paragraphs for Discussion - Discussion lost momentum to me whereas from Introduction through Results was really interesting and punchy. I am not sure whether there needs to be a reporting checklist (SRQR and/or COREQ) - will leave to editorial team to advise

REVIEWER	Tanisha Jowsey Centre for Medical and Health Sciences Education, University of Auckland, New Zealand
REVIEW RETURNED	16-Jan-2019

GENERAL COMMENTS	This is really an impressive paper. Thank you for the opportunity to read what you've been up to in the N.T. I've made three suggestions below, all of which are really just for polishing and you don't need to take any of them on board really. I'll leave it up to you. Page 6 line 110/50 the ACCHS acronym is defined but it includes Torres Strait Islanders in the defining and not in the acronym. For an international audience this might need some explaining. I think it might work better to start that sentence with an orientation to Australia kind of sentence. something like: 'In Australia, there are indigenous-specific PHCs called ACCHSs, these offer tailored PHC to Aboriginal and Torres Strait Islander peoples.' in your key finding concerns teamwork collaboration and shared understanding, I found myself wondering how many of your participants identified as Aboriginal and/or Torres Strait Islander. It would be really interesting to see a breakdown in terms of the types of participants you had, for example, how many of the health service staff identified as ATSI? Having this information could inform my reading of that section, the beautiful quote about this being more than chronic disease data because its my family, could resonate with other staff. Similarly, it enhances with the 'two way learning' stuff. Do you have the numbers? If so, you might consider including them in the table or the beginning of that findings section on p16. p27 - the other theme about engagement wtih community (lines 571-7) - I'd delete this. It already shines through as part of other themes and the way its framed here isn't as strong. The discussion covers all of the right stuff. Best wishes for this paper.

REVIEWER	Christos Lionis Medical Faculty, University of Crete, Greece
REVIEW RETURNED	20-Jan-2019

GENERAL COMMENTS	Dear Editor, Many thanks for kindly inviting me to review this interesting qualitative paper from Australia.

	It is in an interesting in-depth study that deserves attention and potential publication. However, there are some issues that needed to be discussed in a revised format. I am starting with some methodological issues: (a) It is unclear in the text how the research team select the six indigenous health services. The authors could offer some information and justification for their choice. (b) Questions are also raised in regards the four data sets for the case studies. The authors mentioned in the page 7 that “a participatory and strengths-based approach was used to investigate how CQI worked..”. How this statement is documented by the four data sets? (c) I am also asking the authors why did not use another quite dynamic procedure to collect data that foster learning from the community and at the same time promotes engagement (Participatory and Learning Action/PAL)? There are also some minor issues including the discussion section including the following: • Although the authors refer the readers to another paper to be informed about the method used to calculate the high-improvement category of health services, it would be worthwhile if they will offer a short description of it. • The insertion of some meaningful headings like main findings, highlights from the literature, the impact of the study could facilitate the paper’s readiness. • The authors are also invited to discuss the impact on their study in other settings outside of Australia. The case of migrant crisis and demographic changes that reported from Europe offer an important ground for a discussion about a two-way learning process and the necessary efforts to the implemented strategies to be adapted to the historical and community context. • A last point and suggestion to the authors is to include in their discussion some important statements from the WHO Astana Declaration on Primary Health Care (https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf) and the associated vision for primary health care document (https://www.who.int/docs/default-source/primary-health/vision.pdf) especially when they are discussing conceptual frameworks of levers for change in healthcare and quality improvement in primary care.

VERSION 1 – AUTHOR RESPONSE

Thank you for reviewing this article. Our responses are highlighted in track changes and detailed below. As per requirements a Main Document clean copy is attached.

The details of changes are in reference to the Main Document (Marked Copy)
Comment: Table 1: spell out abbreviations eg DMS in footnotes. Row 3 "support from Menzies" likely to require extra explanation for readers outside Australia.
Response: Thank you for highlighting – p37 table 1 Abbreviations are spelt and Menzies removed

P12 Lines 198-204 writing swaps to first person (having been in 3rd person previously) which is a bit distracting.

Response: Rewritten to third person p10/11 line 211-214

P22 Lines 454-458 seemed repetitive - have presented this info earlier in Results.
Response: Now p21 lines 474-478 This was included as a sign post for readers for the upcoming section and we have retained this but happy to remove if editors feel the headings are sufficient for flow.

Theme "Understanding and responding to historical and cultural context" - I found this section really interesting and illustrated clearly and elegantly with text and quotes. I could not see how historical context came through here though - it was clearly important to work within an indigenous cultural framework, but throughout text, it is written about "historical context" as well, which I did not grasp through the information presented both in text and quotes. So I would suggest authors consider presenting something about the history of ?establishment of dedicated indigenous healthcare services, or history of some element of indigenous healthcare (or something else relevant to historical context) or consider re-wording this theme to "Understanding and responding to cultural context"
Response: This is a useful comment thankyou. Now in the results section there is brief commentary about what we mean by historical context and a quote that illustrates the importance of the history of the community. P22 493-505

P23 Line 514-518 - consider moving this up to start of this section.
Response: Thank you this section is moved to the start of section and can be found p22 lines 486-490

P25 Line 518-9: the end of this sentence is really awkward, which is a contrast to how smooth/easy-to-read the rest of the text is
Response: Further clarification and rewording to set up the quote p 25 line 563-564

P25 Lines 527-531: it was not clear to me how this example shows how the community is driving healthcare (2nd example much clearer to me) - seemed there were community members on a committee along with other stakeholders - a bit more description here would be helpful
Response: Further clarification and description as requested p25 579-581

Discussion I think could be improved by condensing - I see author guidelines recommend (but don't insist on) 5 paragraphs for Discussion - Discussion lost momentum to me whereas from Introduction through Results was really interesting and punchy.
Response: One paragraph removed p29/30 679-689

Reviewer: 2
Reviewer Name: Tanisha Jowsey
Institution and Country: Centre for Medical and Health Sciences Education, University of Auckland, New Zealand Please state any competing interests or state ‘None declared’: none declared. Thank you for the opportunity to read what you've been up to in the N.T. I've made three suggestions below, all of which are really just for polishing and you don't need to take any of them on board really. I'll leave it up to you.

Comment: Page 6 line 110/50 the ACCHS acronym is defined but it includes Torres Strait Islanders in the defining and not in the acronym. For an international audience this might need some explaining. I think it might work better to start that sentence with an orientation to Australia kind of sentence. something like: 'In Australia, there are indigenous-specific PHCs called ACCHSs, these offer tailored PHC to Aboriginal and Torres Strait Islander peoples.'
Response: The reviewers comments are correct and the sentence has been amended (p6 line 109). They are not called Aboriginal and Torres Strait Islander Community Controlled Health Services but

Aboriginal CCHS. The Torres Strait Islander community agrees that they should retain the ACCHS and it is to be seen as including Torres Strait Islanders

in your key finding concerns teamwork collaboration and shared understanding, I found myself wondering how many of your participants identified as Aboriginal and/or Torres Strait Islander. It would be really interesting to see a breakdown in terms of the types of participants you had, for example, how many of the health service staff identified as ATSI? Having this information could inform my reading of that section, the beautiful quote about this being more than chronic disease data because its my family, could resonate with other staff. Similarly, it enhances with the 'two way learning' stuff. Do you have the numbers? If so, you might consider including them in the table or the beginning of that findings section on p16.
Response: Unfortunately we did not collected information on whether staff identified as Aboriginal and/or Torres Strait Islander – we collected gender and job title.

p27 - the other theme about engagement wtih community (lines 571-7) - I'd delete this. It already shines through as part of other themes and the way its framed here isn't as strong.
Response: Lines removed indicated p 29/30 679-689

The discussion covers all of the right stuff. Best wishes for this paper.

Reviewer: 3
Reviewer Name: Christos Lionis
Institution and Country: Medical Faculty, University of Crete, Greece Please state any competing interests or state ‘None declared’: None declared Please leave your comments for the authors below Dear Editor, Many thanks for kindly inviting me to review this interesting qualitative paper from Australia.
It is in an interesting in-depth study that deserves attention and potential publication. However, there are some issues that needed to be discussed in a revised format.
I am starting with some methodological issues:
(a) It is unclear in the text how the research team select the six indigenous health services. The authors could offer some information and justification for their choice.
Response: p8/9 lines 156-165- further clarification on service selection

(b) Questions are also raised in regards the four data sets for the case studies. The authors mentioned in the page 7 that “a participatory and strengths-based approach was used to investigate how CQI worked..”. How this statement is documented by the four data sets?
Response: Statement on design reworded as we did not use the PAR as a methodology p7/8 136-140 but a strengths based research design.

(c) I am also asking the authors why did not use another quite dynamic procedure to collect data that foster learning from the community and at the same time promotes engagement (Participatory and Learning Action/PAL)?
Response: Thank you for your comment, we did not use PAR/PAL as a methodology but we did work in collaboration with the staff at the health centre in taking their advice about who to interview, when to do fieldwork, and ensured that they were informed about the results all along the way. It was up to the service as to whether they wanted to use their results for action. There were workshops with services and researchers where there were opportunities to discuss with other high performing services the findings and implications.

There are also some minor issues including the discussion section including the following:

• Although the authors refer the readers to another paper to be informed about the method used to calculate the high-improvement category of health services, it would be worthwhile if they will offer a short description of it.
Response: Additional information added into this section p8 lines 156-165

• The insertion of some meaningful headings like main findings, highlights from the literature, the impact of the study could facilitate the paper's readiness.
Response: Additional heading Main Findings and Impact of the study added

• The authors are also invited to discuss the impact on their study in other settings outside of Australia. The case of migrant crisis and demographic changes that reported from Europe offer an important ground for a discussion about a two-way learning process and the necessary efforts to the implemented strategies to be adapted to the historical and community context.
Response: Sentence added p34 lines 787-790 regarding applicability of findings to vulnerable and marginalised communities.

• A last point and suggestion to the authors is to include in their discussion some important statements from the WHO Astana Declaration on Primary Health Care (https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf) and the associated vision for primary health care document (https://www.who.int/docs/default-source/primary-health/vision.pdf) especially when they are discussing conceptual frameworks of levers for change in healthcare and quality improvement in primary care.
Response: P32 line 740-743 additional commentary added in reference to WHO Astana Declaration.

VERSION 2 – REVIEW

REVIEWER	Elizabeth Lynch University of Adelaide, Australia
REVIEW RETURNED	01-Mar-2019

GENERAL COMMENTS	Thank you for the opportunity to re-review this manuscript. I really like this paper and think it will be useful for people working in QI and people working with indigenous health services. I think the presentation of Results is elegant and clear, and themes are illustrated well with the quotes and text. I still think editing of the final paragraphs of Discussion and Implications will make this paper even better Minor changes suggested: p6 line 110 - spell out ACCHS p28 L 653 - the current move - is this in Australia, in QI generally? p30 Last 2 paragraphs of Discussion I think would benefit from editing. eg Line 687 could be tightened to The component of community is not perceived as a powerful actor... in the published literature to date. Nonetheless, it is not uncommon... Line 689 ACCHS vs spelling out line 693-695: needs tightening up - eg co-production, wherein equal and reciprocal relationships bw XYZ are core of/underpin public service delivery. Lines 701-702: I suspect that even though participants did not explicitly describe these factors - had these findings been presented to them, I would imagine they would have agreed that yes, they are important (is there any way of knowing whether this

	is the case or is this just my conjecture??..) I think there is something here that people working in this line of work live and breathe but are not necessarily conscious of, rather than "not being worthy of comment" which seems to imply these factors are not really terribly important. I would not be at all surprised if this paper gets cited forever onwards in terms of the importance of understanding culture, 2-way learning and community-driving for successful QI initiatives (in indigenous and non-indigenous settings), so I personally would re-word this sentence. Implications of study: This section I think would benefit greatly from simplification - I think the message is lost in jargon and really is counter-productive to presenting the take-home message from this excellent piece of work. I do not think publications and Declarations should be introduced here (Levesque and Sutherland, WHO Astana Declaration on Primary Health Care) - I found them overwhelming in this section that I think should be wrapping up the "so what" factor of this work I would prefer not to have any discussion of other people's publications of a conceptual framework of levers for change, which even as a researcher I find difficult to read and stay focused - I suspect clinicians and QI facilitators would find this section even more difficult to digest . I personally would delete lines 707-714 I am much more interested in what is presented from start of Line 715: Our findings suggest that there is a need to broaden attention to include not on the regular factors but also X, Y Z (I would delete line 717 which is too jargonny - quadrants are not part of common parlance) Lines 721 onwards are the sort of implications that I think are important and here are presented in a reader-friendly way

REVIEWER	Christos Lionis School of Medicine, University of Crete, Greece
REVIEW RETURNED	15-Mar-2019

GENERAL COMMENTS	The authors responded quite satisfactory to my comments and concerns.

VERSION 2 – AUTHOR RESPONSE

Thank you for your valuable suggestions to strengthen this manuscript.

Thank you for the opportunity to re-review this manuscript. I really like this paper and think it will be useful for people working in QI and people working with indigenous health services.

I think the presentation of Results is elegant and clear, and themes are illustrated well with the quotes and text.

I still think editing of the final paragraphs of Discussion and Implications will make this paper even better Minor changes suggested:

p6 line 110 - spell out ACCHS –

ACCHS spelt out p6 line 110

p28 L 653 - the current move - is this in Australia, in QI generally? –

Added in within the Australian context p28 line 654

p30 Last 2 paragraphs of Discussion I think would benefit from editing. eg Line 687 could be tightened to The component of community is not perceived as a powerful actor... in the published literature to date. Nonetheless, it is not uncommon...

Suggestion gratefully received and amended as suggested p30 lines689-690

Line 689 ACCHS vs spelling out

Acronym used p30 line 692

line 693-695: needs tightening up - eg co-production, wherein equal and reciprocal relationships bw XYZ are core of/underpin public service delivery.

Thank you sentences amended p30 line 694-696

Lines 701-702: I suspect that even though participants did not explicitly describe these factors - had these findings been presented to them, I would imagine they would have agreed that yes, they are important (is there any way of knowing whether this is the case or is this just my conjecture??..) I think there is something here that people working in this line of work live and breathe but are not necessarily conscious of, rather than "not being worthy of comment" which seems to imply these factors are not really terribly important. I would not be at all surprised if this paper gets cited forever onwards in terms of the importance of understanding culture, 2-way learning and community-driving for successful QI initiatives (in indigenous and non-indigenous settings), so I personally would re-word this sentence.

Agree sentence reworded p30 lines 702-704 Alternatively, it might be that in these high-improving services there is implicit knowledge shared by staff, which is not openly discussed but rather deeply ingrained understandings and ways of working.

Implications of study:

This section I think would benefit greatly from simplification - I think the message is lost in jargon and really is counter-productive to presenting the take-home message from this excellent piece of work. I do not think publications and Declarations should be introduced here (Levesque and Sutherland, WHO Astana Declaration on Primary Health Care) - I found them overwhelming in this section that I think should be wrapping up the "so what" factor of this work I would prefer not to have any discussion of other people's publications of a conceptual framework of levers for change, which even as a researcher I find difficult to read and stay focused - I suspect clinicians and QI facilitators would find this section even more difficult to digest .

I personally would delete lines 707-714 I am much more interested in what is presented from start of Line 715:

Our findings suggest that there is a need to broaden attention to include not on the regular factors but also X, Y Z (I would delete line 717 which is too jargonny - quadrants are not part of common parlance) Lines 721 onwards are the sort of implications that I think are important and here are presented in a reader-friendly way

This section has been amended as per suggestions p30-31 lines 708-718