2012

# Evaluation of the GP Super Clinics Program 2007-2008

August 2012

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## Disclaimer

This report has been prepared by Consan Consulting. It is provided to the Department of Health and Ageing, GP Super Clinics Branch based on the data collected in the evaluation of the GP Super Clinics Program 2007-2008 undertaken in 2011.

While due care and diligence has been taken, the results, discussion and recommendations in this report rely on the data collected by Consan Consulting, some of which are reliant on self-report of participants and also are reliant on subjective judgement.

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## Ethics Approval

Ethics Committee approval was sought and gained from the Department of Health and Ageing Ethics Committee (Approval Project 11/2011).

# 1 Executive Summary

The GP Super Clinics Program was one part of the health reforms, including primary care reforms, implemented by a newly-elected Labor government in 2007. The localities of the GP Super Clinics were based on criteria relating to need. The program provided grant funds to the value of $181.7 million for the construction or refurbishment of existing infrastructure for the first 36 GP Super Clinics, across 37 localities.

This evaluation addressed three aspects of the GP Super Clinics Program 2007-2008:

- Implementation: administration of the Program by the Department of Health and Ageing
- Establishment: the planning and construction of the 36 GP Super Clinics over 37 sites established in the 2007-2008 tranche
- Operations: service delivery in the seven clinics which were operational for a minimum of six months prior to the commencement of the evaluation.

In the context of these three aspects, the evaluation aimed to describe the historical context and processes for the implementation and the processes and influences which impacted on the construction of the GP Super Clinics. In the operational aspect it aimed to identify the short term impacts, and the activities being implemented to achieve the GP Super Clinics Program objectives. Learnings were also identified with regard to the three aspects of the program and the potential for informing further investment in primary health care infrastructure and services.

Methods for the evaluation were tailored to each of the aspects of the GP Super Clinics Program. Common methods across each aspect included desk reviews, surveys and interviews with representatives of key stakeholder groups. A value-for-money assessment tool was also developed for the establishment aspect.

## 1.1 Policy to Program Implementation

The Department of Health and Ageing was tasked with the implementation of the GP Super Clinics policy which occurred through the establishment of the GP Super Clinics Branch within the Division of Primary and Ambulatory Care. There is evidence that compliance with the processes for Australian Government policy implementation and regulatory requirements was high. Indeed, many of the learnings about program implementation developed through this aspect of the GP Super Clinics Program are applicable to other grants programs.

The *GP Super Clinics National Program Guide 2008* was developed as an overview of the program following consultation with a range of relevant stakeholders. This *Guide* set out the Invitation to Apply and associated consultation processes in each of the identified GP Super Clinic localities. The *Program Objectives* are deliberately broad to enable the model for each GP Super Clinic to be flexibly tailored to local needs; a factor which proved critical in ensuring applicants could propose models for local health needs and workforce contexts.

The GP Super Clinics Program has been essentially a grants program for construction costs and its management required a diverse set of skills, many of which were not initially available within the Branch. Critically, the skills gaps were recognised early and were either developed, recruited or contracted as the program evolved. The assessment processes for the responses to the Invitation to Apply were robust and involved contributions from experts with the required skills for the tasks.

**Managing a long term program**

In line with the GP Super Clinics Program objectives the GP Super Clinics are expected to provide a range of services and undertake a number of activities over a period of twenty years from the commencement of operations. This will require on-going monitoring and management of the GP Super Clinics Program for twenty years from the date the last GP Super Clinic commences its operations.

The initial focus on performance management has related to the milestones associated with the construction phases. As the program matured, these milestones evolved to more closely align to those commonly used in construction projects. In addition, the current funding agreement details funds recovery or step-in rights of the Commonwealth of Australia where services are not being provided as intended under the agreed operational plan.

Once operational, GP Super Clinics are required to report two or four monthly using templates developed by the GP Super Clinics Branch. This reporting, which addresses activity within the clinics and progress towards achieving the GP Super Clinics Program objectives, is monitored and used to inform the ongoing management activities undertaken by GP Super Clinics Branch. This monitoring activity will gain greater scale and complexity as more GP Super Clinics become operational. This will necessitate the introduction of more efficient reporting mechanisms for the GP Super Clinics Branch and for the GP Super Clinics.

Key Performance indicators have been developed and are currently under consideration for the GP Super Clinics Program. There is potential for linkage of data outputs from the GP Super Clinics electronic health records with the reporting requirements of the GP Super Clinics Branch. If taken up, it would enable greater understanding and comparison of the outcomes and effectiveness of the models of care for the GP Super Clinics Program.

### 1.2 Significant Investment in Infrastructure for Primary Care

The GP Super Clinics Program provided significant investment in primary care infrastructure, and thus required and mostly delivered robust financial, contract and risk management processes, some of which have evolved over the life of the program.

The Program was established in the time of the Global Financial Crisis when many capital investments in construction failed. The completion rates for the GP Super Clinics compare favourably to construction industry experience given the financial conditions. Of the two non-completed clinics out of 37 sites, one is due for completion following further negotiations about funding. The second clinic will not progress, due to the inability of the funding recipients to raise funds above and beyond the grant from the Australian Government.

There were delays in completion of the GP Super Clinics, due to the complexities and associated regulatory requirements which occur in any construction projects. Many of the delays were associated with inaccuracies in estimation of timeframes by funding recipients for construction management.

**Value for Money**

Value for money was assessed using a methodology commonly applied in the construction industry based on ($) cost/$m^2$ and accounting for a range of factors associated with location and construction type. The value for money assessment determined that six of the GP Super Clinics were outside the criteria for value for money. If the extra-ordinary circumstances of three of the GP Super Clinics had been factored into the value for money assessments, it is likely that they would also have otherwise met the value for money criteria. The factors that contributed to the higher cost per square metre for the remaining three sites were not identifiable through the value for money assessment methodology and the advice obtained from the sites. It may well be that further assessment might identify similar extenuating circumstances but this would require further examination.

### 1.3 Compliance with GP Super Clinics Program Objectives

The seven operational GP Super Clinics were established within local communities as sites of excellence in multi-disciplinary primary care providing opportunities for health professional education and training in this type of service model. It was evident in these seven operational GP Super Clinics that there has been significant progress towards achieving the ten GP Super Clinics Program Objectives. Consequently, the GP Super Clinics appear to be meeting unmet needs in their communities.

Patient experiences in relation to the services provided at the GP Super Clinics were overwhelmingly positive, rating the quality of and access to care highly. Patients commonly reported moving from other general practice/primary care settings because of access to appointments and the quality of care at the GP Super Clinics.

Within the seven GP Super Clinics, multi-disciplinary care, facilitated by co-location and by the shared electronic health record was provided by over one hundred and seventy clinicians. These data represent a net increase of GPs and of allied health staff in these communities, not just a transfer of clinicians from local practices.

The model of care is a major determinant in recruiting and retaining clinicians in the GP Super Clinics. Indeed many clinicians indicated that the multi-disciplinary model of care, supported by the associated business model, were major factors in their decisions to work and remain at the GP Super Clinics.

All GP Super Clinics provided some form of access to after-hours care. Bulk billing in some form, mostly to groups such as children less than 16 years, and those on health care cards, was provided by all GP Super Clinics.

The majority of GP Super Clinic Directors indicated they were on track for achieving financial viability. The capacity to bulk bill all patients was questioned by the majority of GP Super Clinic Directors and clinicians. The structure and amount of remuneration under the current Medicare

system was cited as a significant barrier to bulk billing and hence impacted on the capacity of the GP Super Clinics to remain financially viable.

### 1.4 Areas for Service Development

There are a number of aspects of service delivery requiring development across the GP Super Clinics. The multi-disciplinary model of care, as currently provided is mostly reliant on sequential but discrete service episodes provided by a range of disciplines, integrated through co-location under one roof and by the shared electronic health record rather than a shared, planned approach. Where attempts to apply guidelines for multi-disciplinary care have been made they have been informed by guidelines developed specifically for single-professional practice; in most cases for general practitioners. The model of care was further supported by specific Medicare items such as Team Care Arrangements and Chronic Disease Management items.

Multiple professionals working together in one site is relatively new in the primary care setting in Australia, therefore the development of guidelines for multi-disciplinary team-based care is critical to the achievement of the GP Super Clinics Program Objectives. These could be developed is through consortia between GP Super Clinics, universities, professional colleges and other relevant professional groups. Further, due to the significant personal and practice changes involved, a multi-disciplinary team-based skills assessment and skills development program is required for effective implementation of multi-disciplinary guidelines.

The focus on preventative health care has been on secondary prevention, in managing lifestyle risks in people with chronic conditions. Understandably this aligns with the focus in the GP Super Clinics on chronic illness. The potential for impact, and indeed the expectation of primary prevention occurring in GP Super Clinics is high; however demonstration of this was less than optimal. Where it was occurring it was often reliant on patients being referred by the GP to another discipline for intervention. This is a missed opportunity, with a plethora of research indicating the impact of GPs on reducing risk factors in patients, and at a population level.

The utility of electronic health records beyond use as a record for patient care and as facilitators of multi-disciplinary care was not evident. Their utility as tools in organisational, administrative or quality improvement roles has the potential to enhance the quality and model of care in meeting the needs of local communities.

Community engagement occurred mostly in the early phases of the GP Super Clinics. There were some outstanding examples of community engagement with members of local Aboriginal communities. However there was less demonstration of an ongoing and strategic approach to the community engagement required if the GP Super Clinics are going to continue to meet community needs, and those of specific groups with significant health risks.

Ultimately the GP Super Clinics will be expected to provide models of care which support a range of services in meeting local health care needs requiring shared planning and integration with other local primary and acute health care services. While there was limited evidence of progression to an integrated approach to planning, there is potential for this occurring, especially with the support of other reform initiatives.

## 1.5 GP Super Clinics Program Learnings

The seven GP Super Clinics had only been operational for a period of less than 12 months. Within this context, the priorities of the GP Super Clinics, and indeed of the GP Super Clinics Branch, have, justifiably, been on construction, recruitment of workforce, and building systematic capacity to achieve the GP Super Clinics Program objectives. With this in mind, it is not surprising that all aspects of the GP Super Clinics Program objectives have not been achieved. However it is now timely that the GP Super Clinics and the Department of Health and Ageing collaborate and consider the longer terms strategic priorities which will enable the continued implementation of the GP Super Clinics policy. This is a responsibility of individual GP Super Clinics and of course this makes sound business sense. From the broader national policy perspective, it is a responsibility of the Department of Health and Ageing to support the GP Super Clinics in their service development to ensure the investment in primary care is realised.

## 1.6 System Learnings

The results of this evaluation suggest a number of learnings which are not specifically relevant to the GP Super Clinics Program, but could be considered more broadly for the primary health care system.

### Measuring Primary Health Care Performance

Measurement of performance is undertaken in health services and systems to determine the extent they meet expected objectives and outcomes, and importantly for determining the return on investment of public money. The primary health care system should be no different. However to date, the lack of agreement on measures which accurately reflect primary health care and its complexities have, in Australia, prevented this happening. In the absence of performance measurement, the ability to develop improved primary health care systems is limited.

### Medicare Benefits Schedule

Medicare items have consistently been raised as barriers to implementing effective multi-disciplinary care. This problem needs to be addressed in the broader context of further primary health care reform across a range of platforms with greater linkages between the Medicare Benefits Schedule (MBS) including its Practice Incentives Program (PIP) and other primary health care funding streams.

### Role of Universities and Colleges

The capacity of the future primary health care workforce is largely dependent on the training of future health professionals. Partnerships with universities have been established by many of the GP Super Clinics. Most of the GP Super Clinics have provided clinical placements for students, and in some cases training for General Practice Registrars.

Currently these partnerships focus on universities or General Practice Regional Training Providers meeting their demand for clinical placements, with little evidence of any changes to their learning programs, and in particular, of a move to a multi-disciplinary experiential environment for students. Ideally, programs at universities will develop to a more sophisticated approach to learning across disciplines reflecting 21st century primary health care aligned with

the empirical evidence. That this is rarely occurring, with learning still occurring in discipline-specific silos, is a missed opportunity for students, trainees and patients.

### 1.7 Summary

The GP Super Clinics Program is in the early stages of maturation, with the ground for reforms in this facet of primary health care being laid with increased investment in infrastructure with the establishment of GP Super Clinics. However, the GP Super Clinics Program is ultimately about patients and their ability to access high quality primary health care. The results of this evaluation at this stage of the GP Super Clinics Program demonstrate that patients have increased access to primary health care in a multi-disciplinary setting and report positive experiences about access to and the quality of their care. Further, the Program is supporting retention and potentially recruitment of GPs into clinics which have the potential to be at the forefront of primary care reform. It will only be as the GP Super Clinics Program matures that the real return on investment in primary health care can be adequately assessed.

In this light, recommendations for enhancing the GP Super Clinics Program and service development for the GP Super Clinics have been made and are included in the final chapter. These recommendations also reflect on learnings of the GP Super Clinics Program for improvement and potentially for consideration by similar programs.

# 2 Introduction

## 2.1 Scope of Evaluation

This evaluation was undertaken for the GP Super Clinics established between 2007 and 2008. It focused on three aspects of the GP Super Clinics Program:

- Implementation: the administration of the Program by the Department of Health and Ageing
- Establishment: the planning and construction of the 36 GP Super Clinics across 37 localities established in the 2007-2008 tranche
- Operations: service delivery in the seven GP Super Clinics which were operational for a minimum of six months prior to the commencement of the evaluation

The evaluation is focused on the GP Super Clinics Program 2007-2008 as implemented by the Department of Health and Ageing and the establishment and operations of the GP Super Clinics from the perspectives of Clinic Directors, clinicians and importantly patients. It is not an evaluation or an assessment of the policy which guided the GP Super Clinics Program.

## 2.2 Background

In the lead-up to the 2007 Australian Federal Government election, the Australian Labor Party, then in Opposition, announced primary health care reforms which included the establishment of GP Super Clinics.[1] Their policy document, *New Directions for Australia's Health: Delivering GP Super Clinics to Local Communities,* articulated the increased investment in primary care through the delivery of GP Super Clinics.

The establishment of the GP Super Clinics aimed to encourage general practitioners (GPs) to practise in localities of identified GP shortages and to deliver more services focused on patients with chronic disease and the associated disease burden on the community. This included the provision of allied health services and a stronger focus on preventative health care and chronic disease management.[1]

With the election of the Labor Government in November 2007, changes in primary health care were included as part of the new government's overall approach to health care reform. The criteria for selection of localities for the GP Super Clinics were areas where:

- Access to health services was poor
- Health infrastructure was underperforming
- The provision of a GP Super Clinic could take pressure off emergency departments
- Levels of chronic disease were high and/or there were populations with high needs such as large numbers of children, or a higher proportion of older people who have higher health needs than the general population

- Areas currently experiencing or anticipated to experience rapid population growth[1]

The 31 localities for GP Super Clinics which were initially announced are identified in Table 1. In 2009 a further five localities were identified for inclusion in the GP Super Clinics Program for the 2007-2008 tranche:

- Cockburn (Western Australia)
- Gunnedah (New South Wales)
- Portland (Victoria)
- South Morang (Victoria)
- Wodonga (Victoria)

**Table 1: Localities Identified as GP Super Clinics in 2007**

| NSW | Queensland | Tasmania |
|---|---|---|
| Blue Mountains[1] | Brisbane Southside[1] | Burnie[1] |
| Grafton[1] | Bundaberg[1] | Devonport[1] |
| North Central Coast[1] | Cairns[1] | Hobart Eastern shores – Clarence (Site A)[1] |
| Port Stephens[1] | Gladstone[1] | Hobart Eastern shores – Sorrell (Site B)[2] |
| Queanbeyan[1] | Ipswich[1] | **Victoria** |
| Riverina[1] | Redcliffe[1] | Ballan[3] |
| Shellharbour[1] | Strathpine[1] | Bendigo[3] |
| Southern Lake Macquarie[1] | Townsville[1] | Berwick[1] |
| **Northern Territory** | Mt Isa[3] | Geelong[3] |
| Palmerston[2] | **South Australia** | Wallan[1] |
| | Modbury[2] | **Western Australia** |
| | Noarlunga[2] | Midland[2] |
| | Playford North[2] | Wanneroo[2] |

1 Localities administered by Commonwealth-led invitation to apply process

2 Localities progressed jointly by the Commonwealth and the relevant state or territory government

3 Localities where funding process was conducted with an identified recipient

The Australian Government committed $181.7 million to establish GP Super Clinics as part of the overall investment in primary health care services.[2] This funding involved three separate processes for allocation, which were determined by the Australian Government and were outlined in the *GP Super Clinics National Program Guide 2008*:[2]

- Funding through a Commonwealth-led Invitation to Apply process
- Funding progressed jointly with states and territories
- Funding process with identified recipients at the nominated localities

The level of investment for each site was determined by the Australian Government and was detailed in the *GP Super Clinics National Program Guide 2008* for each locality.[2] In some instances matched contributions from state and territory governments were also available.[2]

Following the Federal election and the change of government in November 2007, the Department of Health and Ageing was tasked with the implementation, establishment and ultimately the operational components of the GP Super Clinics Program. These three aspects were developed and managed initially by Primary Care and Chronic Disease Branch and then

by the GP Super Clinics Branch established within the Primary and Ambulatory Care Division of the Department of Health and Ageing.

### 2.3 Program Objectives

The ten objectives of the GP Super Clinics Program described as characteristics of the service delivery model are contained in Appendix 1. A key focus of the service delivery model was the delivery of multi-disciplinary care by different disciplines and service providers through physical or virtual co-location, working as teams.[2] The nature and range of services provided under the GP Super Clinics were to be tailored to the needs of local communities. While these services were not prescriptive, it was expected that the funded GP Super Clinics would demonstrate the following core characteristics in their service delivery model represented in the GP Super Clinics Program objectives:[2]

- Well-integrated multi-disciplinary patient centred care
- Responsiveness to local community needs and priorities including those of Aboriginal and Torres Strait Islander peoples
- Accessible, culturally appropriate and affordable care
- Support for preventative care
- Efficient and effective use of technology
- An environment conducive to recruitment and retention of workforce
- High quality best practice care
- Viable, sustainable and efficient business models
- Support for the future primary care workforce
- Integration with local programs and initiatives.

### 2.4 What is a GP Super Clinic?

The GP Super Clinics were established within local communities as new or refurbished facilities. It was expected they would be sites of excellence in primary care service delivery and would provide opportunities for health professional education and training with a multi-disciplinary focus.[2] They were to provide a broad range of services that targeted the health needs of local communities by bringing together a range of clinicians, including general practitioners, practice nurses, visiting medical specialists and allied health professionals.[2] Models of care were expected to reflect best practice multi-disciplinary and integrated care focusing on chronic disease and preventative health care.

## 2.5 The Need for Reform

Governments in many developed nations have recognised the need for health system reform, to address increasing demand related to ageing and chronic disease, system fragmentation, equitable access, efficiency, costs, safety and quality.[3-7] These challenges have contributed to the World Health Organisation (WHO) articulating the need for refocusing on a strong primary health care sector globally.[8]

In Australia, a number of key reasons have been identified for the need for reform with an emphasis on primary care. The first relates to the burden of disease and increasing rates of chronic disease and ageing, resulting in increased demand for a range of health services.[9] The second relates to the need to reduce admissions and length of stay in hospitals by providing clinically appropriate care in the community. Aligned to the focus of WHO, the third reason relates to the need for greater geographical, financial and health condition equity in access to primary health care services.[9,10] Further, an ageing and inequitably distributed health workforce continues to place pressure on the current primary health care system, requiring a focus on workforce capacity building as part of primary health care reform.[9]

## 2.6 Primary Care Critical to Health Outcomes and Equity

Primary care addresses the most common health problems in the community, integrates care where there are multiple health problems and addresses the context in which illness occurs.[9] The WHO identifies primary care as the linchpin of health equity and achieving health outcomes for all, supported by robust theoretical and empirical evidence, with strong national primary care systems associated with improved equity and health indicators.[8,11,12]

In both developed and developing nations, evidence exists for the link between a strong primary health care system and equity.[13] Generally, primary health care is perceived as more equitable than other forms of health care, in part because it requires fewer resources.[13] Numerous studies have identified the link between strong primary health care and improved health outcomes related to mortality, morbidity, patient experiences and self-reported health status.[13,14] These outcomes are commonly associated with lower expenditure on individual and system costs.

## 2.7 Models for Primary Care and General Practice

Internationally, models of primary care have evolved over the last decade with some common elements. Evidence suggests that organisational structures such as joint ventures and alliances can support achievement of health outcomes while ensuring sustainability of business models.[15]

While the nature of the models differs, most developed nations have attempted to implement organisational structures to support development and coordination of local primary care services.[16] Evidence does not exist to support a particular organisational model, with variations in type of organisation, governance, legitimacy and capability.[16] Commonly, co-location of multiple services under one organisational clinic structure has developed in various forms to deliver more integrated care, particularly for people with chronic diseases.[4] Regardless of the model, it has been identified that new organisations in primary care need time and stability to build capability, trust, culture and systems in sustainable ways.[16]

Trends in models of primary health care have also seen an increase in organisations that provide comprehensive services to particular populations. [7] These services are provided by multi-disciplinary teams, with enhanced roles for nurses, pharmacists and other providers.[7] There has also been an increased emphasis on health promotion, disease and injury prevention, and management of chronic illnesses.[7] Workforce and organisational model trends in general practice have seen shifts from single to multiple GP practices, from single to multi-disciplinary practices, and from practitioner autonomy to greater accountability.[4,16]

Funding of general practice and primary care has seen a shift towards payment structures which reflect broader system requirements and a move from general practitioner focused fee-for-service payments to blended payments incorporating elements of capitation, patient co-payment and incentive payments.[9] Payments for specific activities have also been used to increase provider activity in certain areas.[16]

In Australia there have been many initiatives designed to address some of the pressures in general practice and in primary care. However, many of these have been localised and not sustained.[16] Organisational models reflected in Divisions of General Practice or Networks have limited capacity to improve integration and coordination of care and to improve health outcomes for the local population in the absence of health system reform.[16]

Recent emphasis in models in the United Kingdom have been driven by the need for greater flexibility and shifting the balance of power to primary health care, to the practice level and to consumers.[16] There have been three key changes in the way primary care is delivered in the United Kingdom: patients are now registered with a practice not an individual GP; out-of-hours care is not provided by the GP but rather is provided by primary care organisations, some of which may sub-contract to GP practices; and 25% of GP income now relates to the quality targets of the United Kingdom's Quality and Outcomes Framework which provides additional financial rewards to those practices that deliver agreed levels of patient care, based on a points system.[16]

Evidence for the effectiveness of primary care provided under service models such as those provided through GP Super Clinics suggests various impacts.[17] Outcomes related to patient experiences of communication and coordination, and health outcomes for chronic disease and for quality and efficiency have been demonstrated under health services which are structurally integrated and provide a continuum of services.[17] Higher quality of care in group general practices is reported compared with single or small practices, and in those accredited as training practices.[18]

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# 3 Evaluation Aims and Methods

## 3.1 Evaluation Aims

The evaluation aims were to:

- Describe the historical context that led to the development of the GP Super Clinics Program
- Examine the process for the implementation of the GP Super Clinics Program
- Identify the processes and influences which impact on the construction of the GP Super Clinics
- Identify the short-term impacts of the GP Super Clinics Program at those sites which are operational
- Identify the approaches being implemented by (operational) GP Super Clinics that support them to meet the objectives of the Program
- Examine the learnings so far with regard to the three aspects of the GP Super Clinics Program, and consider how these can inform further investment in primary health care infrastructure and services.

The evaluation had primary and secondary evaluation questions for each of the three aspects of the GP Super Clinics Program: implementation, establishment and operations. These questions are included in Appendix 2.

## 3.2 Evaluation Methods

The methods for the evaluation were tailored to the three aspects of the GP Super Clinics Program:

- Implementation: the administration of the Program by the Department of Health and Ageing
- Establishment: the planning and construction of the 36 GP Super Clinics across 37 sites
- Operations: service delivery in the seven GP Super Clinics which were operational for a minimum of six months prior to the commencement of the procurement for the evaluation.

Ethics Committee approval was sought and gained from the Department of Health and Ageing Ethics Committee (Approval Project 11/2011).

### 3.2.1 Methods for Implementation Aspect

Desk reviews of the documents associated with this phase of the GP Super Clinics Program were undertaken by two members of the consultancy team. The documents subject to the desk

review were identified and confirmed by the evaluators in conjunction with Department of Health and Ageing staff. These documents included:

- *New Directions for Australia's Health: Delivering GP Super Clinics to Local Communities*[1]
- *Building a 21st Century Primary Health Care System: Australia's First National Primary Health Care Strategy*[3]
- *A Healthier Future For All Australians – Final Report of the National Health and Hospitals Reform Commission*[5]
- *GP Super Clinics National Program Guide 2008*[2]
- *GP Super Clinics National Program Guide 2010*[19]
- *Primary Care Infrastructure Grant Guidelines 2011*[20]
- *Commonwealth Grant Guidelines: Policies and Principles for Grants Administration 2009*[21]
- A random selection of Department of Health and Ageing documents from each of the "rounds" of the Program including examples of:
    - Applications
    - Operational Plans
    - Project Plans
    - Funding Agreements

It is noted that the Commonwealth Grant Guidelines were not in place at the commencement of the implementation aspect of the Program but were published during this period. As such, these guidelines were not used by the GP Super Clinics Branch to guide all elements of the implementation aspect. However, they have been used as part of the checklist developed for the evaluation for determining the extent of compliance with policy implementation.

The assessment tool to be applied to all the documents was developed by the evaluation team. The tool reflected the key elements of the agreed documents. It was developed iteratively between the evaluators in order to ensure it comprehensively addressed all aspects of the documents.

The initial stage of the desk review involved two evaluators independently assessing one set of documents to ensure that the assessment tool was being applied consistently. The separate results of this process were compared to identify areas of inconsistency between the two assessments. Points of difference were identified and discussed until agreement was reached. This process was repeated until consistency in the application of the assessment tool was reached. The assessment tools were then applied to all agreed documents. Within each of

these areas further grouping occurred related to areas of full compliance, partial compliance or non-compliance with the elements of the assessment tool.

Interviews with Department of Health and Ageing staff who were involved in the program implementation were undertaken. Interview questions focused on the process of policy implementation. The interviews aimed to complement the information derived from the desk reviews assessment process and to explore the factors impacting on the implementation aspect.

### 3.2.2 Methods for Establishment Phase

The methods for the establishment phase included five elements:

- Desk reviews
- Surveys of GP Super Clinic Directors
- Surveys of Department of Health and Ageing staff involved with specific sites
- Telephone interviews with GP Clinic Directors
- Development and application of a value for money tool.

**Desk Reviews**

Desk reviews of the documents associated with the establishment aspect of the Program were undertaken by the member of the consultancy team with significant experience in assessment and evaluation of major construction projects across Australia. The documents included those relevant to the construction phase including:

- Development applications
- Project Plans, where available
- Variation notices.

These documents contained information about construction, associated funding and milestones. The purpose of the desk review was to identify the processes for construction and variations in timelines and budgets.

**GP Super Clinic Directors Survey**

A pen-and-paper survey was sent to the GP Super Clinic Directors (funding recipients) to provide information on the construction of the GP Super Clinics and to verify and further explore the processes and variations for construction.

**GP Super Clinic Directors Interview**

The GP Super Clinic Directors were asked to participate in semi-structured interviews. The interview aimed to support the completion of the survey and was thus tailored to each of the GP

Super Clinics, dependent on the information provided in the survey. Additional information sought in the interview included factors which impacted on construction.

**Department of Health and Ageing Staff Survey**

A pen-and-paper survey was forwarded to Department of Health and Ageing staff with site-specific responsibility for each of the GP Super Clinics. The purpose of the survey was to gather perceptions of the processes of construction and reasons for variations, to allow comparison with the perceptions of GP Super Clinic Directors.

**Value for Money**

The value for money tool was developed by members of the evaluation team with expertise in construction and quantity surveying. The value for money evaluation methodology was based on:

- A location factor, recognising the projects' remoteness from large population centres and industry with correspondingly higher costs per square metre ($m^2$)
- A construction complexity factor, in the form of three light/medium/heavy construction categories, recognising that construction costs rise as construction complexity rises
- A construction type factor, related to new construction, building conversion, building refurbishment or tenancy fit-out, recognising the lower construction costs as the extent of new construction work decreases under each of these categories
- A timing factor, recognising when the construction was or will be carried out, with commensurate allowance in the range of prices (per $m^2$) for escalation.

Cost templates were developed for comparison with the cost information provided by respondents to the Establishment Aspect surveys for the assessment of value for money.

This evaluation methodology is commonly and routinely used throughout the property industry, in particular as a method of checking feasibility or viability of development projects. To ensure that any "underage" or "overage" in the cost of one element of a project (e.g. car parking, consultants' fees, fixtures, furnishings and equipment) does not affect the assessment of the dollar ($) cost per $m^2$ of the building works, the surveys sought information on these other elements so that they could be excluded from the assessment. Where any of these elements was valued by the survey respondents at substantially higher or lower costs than quantity surveyors assessed as reasonable, further enquiries of the respondents were made. In most cases, the cost information originally provided by the respondents was amended, with this amended information used in the value for money assessment.

### 3.2.3 Methods for Operations Aspect

The operations aspect of the evaluation involved a number of methods to capture data from a range of stakeholders involved across the seven sites. Participation was voluntary. Patients and clinicians were informed that there would be no adverse consequences as a result of not agreeing to participate in completion of the survey or in semi-structured interviews.

**GP Super Clinic Directors On-line Self-assessment Form**

An on-line self-assessment form was developed to enable each Director to detail the extent of implementation of approaches aligned to the GP Super Clinics Program objectives. Each Director was sent an email with a unique link to an on-line self-assessment form. The email included a letter of invitation to the evaluation. Completion of the on-line self-assessment form was considered to be consent. The online-survey system automatically provided prompts for those who did not respond. Two reminder emails were sent to non-responders.

**Patient Survey**

Patients over 18 years of age attending any of the seven GP Super Clinics two weeks prior to the site visit were asked by reception staff to complete pen-and-paper surveys. All seven GP Super Clinics were sent 150 surveys in envelopes. The GP Super Clinics were also sent an instruction sheet for the provision of the surveys, for use by reception staff. This sheet addressed procedures for:

- Providing patients with the envelope containing the survey and letter of invitation
- Assessing eligibility
- Identifying patients from Non-English-speaking backgrounds (NESB)
- Answering questions patients may ask about the survey and its completion
- Returning all sealed surveys to the evaluation team.

Eligibility criteria related to whether patients were considered cognitively able and physically well enough to complete the survey. Patients considered cognitively able were those who could converse at a level equivalent to year 10 education. In line with standard patient categorisation methods used in general practice, patients with conditions identified by reception staff as non-urgent or not requiring immediate medical attention were classified as physically well enough. Staff at the GP Super Clinics placed notices regarding the evaluation in the waiting rooms and on the reception counters.

Patients were advised about the survey by reception staff and shown where they could access unsealed brown envelopes which contained the patient letter of invitation and the patient survey. Those identified as NESB patients were offered white envelopes containing the survey, an information sheet for their family members to support the patients completing the surveys, and stamped self-addressed envelopes which allowed the patients to post the completed surveys to the evaluators. Reception staff asked the NESB patients to discuss the survey with their families and if completed, to return it in the supplied reply-paid envelopes.

The aims of the patient survey were to:

- Assess patient perceptions of the GP Super Clinics in relation to
    - accessibility

- affordability
- cultural and linguistic relevance

- Examine whether perception is associated with age group, gender, employment status, country of birth and health insurance status

- Assess patient self-report of clinician discussion of lifestyle risks, screening and management of health conditions

The survey included items on demographics, access to primary health care, and experiences related to the GP Super Clinics Program objectives. The data from the survey were entered into Excel and transferred to Stata statistical software for analysis.

**Clinician Survey**

The Director of each of the seven GP Super Clinics was asked to provide the names, positions and contact emails for each of the clinicians who provide services at the GP Super Clinics. Clinicians included general practitioners, medical specialists, and nursing and allied health staff. To encourage participation in the survey, information notices were provided for display in the staff rooms at the GP Super Clinics and for inclusion in staff newsletters. Clinicians had the option of declining the request for their details being sent to the evaluation team. Participation was voluntary, and staff were informed that there would be no adverse consequences as a result of not agreeing to have their contact details sent to the evaluation team.

The aims of the clinician survey were to:

- Assess clinicians' perceptions of:
  - the importance of key elements of the GP Super Clinics Program in providing high quality primary care
  - how well elements of high quality primary care were being implemented in their GP Super Clinics
  - the factors which support multidisciplinary care in their GP Super Clinics.

- Compare patient report and clinician report of clinician discussion of lifestyle risks, screening and management of health conditions.

The evaluation team was provided with the names of 131 clinicians. The clinicians were sent emails requesting their participation in an online survey by completing the survey within two weeks of its receipt. The email included links to a letter of invitation outlining the evaluation and the survey. The on-line survey system automatically sent non-responders or partial responders reminder emails after five, nine and twelve days. The survey focused on their experiences in providing services at the GP Super Clinics in line with the Program objectives.

**Site Visits**

Site visits to each of the seven operating sites were undertaken. Semi-structured interviews were conducted for each of the stakeholder groups including:

- GP Super Clinic Directors
- Clinicians
- Patients
- Community stakeholders

Notices about the interviews for clinicians, staff and patients were provided in waiting and staff rooms. Information sheets and consent forms were provided to the consenting participants. For this evaluation the community stakeholders were those who had been involved in the early stages of the development of the GP Super Clinics. The names of these community stakeholders were provided by the GP Super Clinic Directors to the evaluation team. These community stakeholders were contacted by telephone by a member of the evaluation team. Information about the evaluation was provided to each stakeholder verbally. If stakeholders indicated willingness to participate in interviews they were sent information about the evaluation and consent forms by email.

The interviews were tailored to each of the stakeholder groups relevant to their discipline and/or their role in the development and operation of the GP Super Clinics. The interviews were held in separate (private) rooms at the GP Super Clinics. A log of the interviews for each stakeholder group was recorded with data on age, gender and discipline of clinicians. Each interview was recorded, and all interviews were analysed for common themes.

### 3.2.4 Statistical Analyses for Surveys

**Patient Survey**

Socio-demographic characteristics of the patient sample, such as age group, gender, employment status, country of birth, Aboriginality, marital status, health insurance status and GP Super Clinic attendance characteristics, are presented using frequency distributions. The percentage of respondents who agreed or strongly agreed with each reason for attending the GP Super Clinics, and the percentage who reported that their clinicians had sometimes or always discussed lifestyle risks, screening and management of health conditions are reported with 95% confidence intervals. Confidence intervals for proportions were adjusted for clustering of patients within clinics using the survey commands in Stata.

**Clinician Survey**

Socio-demographic characteristics of the clinician sample, such as age group, gender and employment category, are presented using frequency distributions. The percentage of clinicians are reported with 95% confidence intervals who: rated the importance of each of the elements of the GP Super Clinics Program as high or very high (levels 4 or 5); considered that each of these elements was being extensively or fully implemented (levels 4 or 5); agreed or strongly agreed

with factors supporting multi-disciplinary care; and reported that they sometimes or always discussed aspects of patients' preventative health care.

## 3.3 Sample Sizes

### 3.3.1 Patient Survey

Assuming a design effect of 1.3, a sample size of 500 patients would allow estimation of proportions with 95% confidence intervals within ± 5% of the point estimate. At a response rate of 60%, it was estimated that 840 patients should be approached to participate in the survey.

### 3.3.2 Clinician Survey

It was anticipated that approximately 140 clinicians would work across the seven operational GP Super Clinics. Assuming a minimum response rate of 50%, the evaluation would be able to estimate proportions with 95% confidence intervals within ± 12% of the point estimate.

## 3.4 Structure of This Report

The structure of this report reflects the three aspects of the Australian Governments GP Super Clinics Program: implementation, establishment and operations. The results of the data collection in each of these aspects are reported in chapters 4 to 6. The final chapter discusses the key learnings and recommendations for the GP Super Clinics Program and for the broader primary health care system, based on the results of this evaluation.

# 4 Implementation Aspect

The implementation aspect of the GP Super Clinics Program addressed the process of translation of government policy and announcements for localities and the scale of investment for each capital works project into the reality of the Program.

## 4.1 Policy Alignment

The GP Super Clinics Program aligns with the major health, and in particular primary health care policies of the Australian Government, such as the National Primary Health Care Strategy.[3] This strategy provides the platform for primary health care system reform in Australia and is aligned to the National Health and Hospitals Reform commitment to strengthening the primary care sector.[5] The policy reflects empirical evidence that effective primary care in local communities means people stay healthier, manage chronic disease and illness more effectively, and stay out of hospital.[3,9]

The policy approach mirrors that of many developed nations, and organisations such as the World Health Organisation.[6,7,10,22-24] Many of these reforms focus on primary care as the centre-piece of the health system to deliver equitable, people-focused services, supported by accountability, responsiveness and a strong focus on the health of populations.[10]

## 4.2 Governance

The Council of Australian Governments' (COAG) had responsibility for oversight and approval of the GP Super Clinic initiatives. Specifically, the Health and Ageing Working Group (HAWG) of COAG had responsibility for developing the bilateral working relationships with states and territories in order to progress the site-specific discussions about arrangements for location. The membership of HAWG included representatives of the Prime Minister and Cabinet and Treasury.

The Department of Health and Ageing was tasked with the conversion of the government policy into the GP Super Clinics Program 2007-2008. The GP Super Clinic Branch was established within the Primary and Ambulatory Care Division of the Department of Health and Ageing to progress policy implementation.

## 4.3 Compliance with Regulatory Requirements

The results of the checklist used to assess the extent to which implementation aligned with the regulatory requirements and guidelines associated with sound public administration demonstrate evidence of compliance with most aspects specified in the *Commonwealth Grant Guidelines Policies and Principles for Grants Administration*.[21] Areas of compliance where there were issues of uncertainty related to measurement of performance and outcomes in relation to the operations aspect of the GP Super Clinics Program.

The establishment aspect of the GP Super Clinics Program 2007-2008 required reporting of milestones relevant to the phases of construction and associated funding. These were reported in Project Plans, Funding Agreements and Deeds of Variation.

In the operations aspect, the GP Super Clinics are expected to report on their activities toward achieving the objectives of the GP Super Clinics Program. These objectives are broad, contain multiple concepts and at this stage, lack the development of specific indicators against which their achievement can be measured. Key performance indicators for the GP Super Clinics are currently under consideration and should inform a better understanding of the achievement of the GP Super Clinics Program.

At a minimum, senior managers of the GP Super Clinics are expected to provide two-monthly reports on services provided by the multi-disciplinary workforce of their clinic. In addition, they are also expected to report three times a year on progress towards achieving the ten GP Super Clinics Program objectives, as well as an annual report examining the activity of each Clinic over the previous 12 months, and proposing plans for the upcoming 12 months. Under the funding agreement with the Australian Government each GP Super Clinic has a designated use period of 20 years from commencement of operations. This necessitates long term program management for twenty years from the time of commencement of operations of the last of the GP Super Clinics to begin providing services. The role of the Department of Health and Ageing over this period will continue to focus on how the GP Super Clinics are delivering services to achieve the GP Super Clinic Program Objectives.

### 4.4 Capacity Building within the GP Super Clinics Branch

In the initial stages, the GP Super Clinics Branch was primarily focused on the establishment aspect, with the provision of funds for construction or refurbishment of buildings. In addition to knowledge and skills related to primary care, this required an understanding of construction, contract management and probity issues, expertise which was not available in the Primary and Ambulatory Care Division or in the newly established GP Super Clinics Branch at the time of implementation. As a result of these gaps being recognised, expertise in these issues was recruited or contracted or occurred through partnership development with other branches within the Department of Health and Ageing.

#### Development of Funding Agreement

After consulting internally across capital works programs in the Department of Health and Ageing, the Branch worked with external legal advisors to develop the Funding Agreements which would meet the necessary contractual arrangements for the provision of capital funds under the GP Super Clinics Program. While the Department of Health and Ageing had a range of templates in place for Funding Agreements, it was deemed that external independent advice with specific capital works experience was required on this aspect of the Program.

Consistent with Department of Health and Ageing (DoHA) requirements, the Program Funding and Procurement Service within DoHA provided guidance and support, to ensure that compliance with all aspects of procurement, policy implementation and risks was effectively managed.

#### Probity

Probity requirements for the GP Super Clinics Program were developed into probity plans. The probity plans were developed separately for competitively and directly funded sites. However, directly funded sites had to meet the probity requirements as if they were competitive. The

purpose of the plans was to ensure all aspects of the distribution of funding were conducted in accordance with all applicable laws and policies and in a manner which a third person would consider to be fair. An independent adviser conducted probity training sessions to ensure staff understood the probity aspects of the Program.

**Risk Management Processes**

Risk management processes were developed within the Department of Health and Ageing. These were developed for the GP Super Clinics Program and for specific sites and were separated from probity with the support of partners within the Department of Health and Ageing.

**Communication Strategy**

Following a decision by the Government that public consultations had to be held in each locality prior to the Department conducting each Invitation to Apply, the Communication Strategy was developed in partnership with the Communication Branch within the Department of Health and Ageing. The strategy supported a number of aspects of the program implementation. It aimed to ensure that the communication of simple messages about the GP Super Clinics Program was applied consistently and repeatedly.

**General Practice Advice**

In the implementation phase of the GP Super Clinics Program 2007-2008, general practice advice was sourced from within the Department of Health and Ageing and from stakeholders including the Australian General Practice Network (AGPN) and Australian Medical Association (AMA). In an ongoing arrangement, the Department contracted GPs to contribute to the assessment processes. This advice informed the development of the *GP Super Clinics National Program Guide 2008*, as well as issues related to general practice and multi-disciplinary care.

**Construction Adviser**

The Construction Adviser was engaged in October 2010 to review the project documentation for GP Super Clinic projects identified by the Department of Health and Ageing with respect to:

- the timelines proposed or anticipated for the selected projects
- review of those timelines and the funding recipient's performance against them, and where appropriate to interview the funding recipient to clarify areas of uncertainty as to the performance to these timelines
- reporting to the Department on the outcomes of the interview and any recommendations to restrict and recover any slippages against these timelines

Other advice provided by the Construction Adviser related to the forms of contract most suitable to the projects and contractual provisions that might be incorporated in those contracts to manage and control time and cost based claims during construction. These services were extended where needed, to include separate advice related to the anticipated costs of individual projects, procedures around statutory approvals of projects, and advice on possible means of accelerating progress on particular projects.

### Independent Financial Advice

An independent organisation offering a range of skills and experience relevant to the financial viability of integrated, multidisciplinary models of care was engaged to provide independent financial advice on the proposals for each site. The resultant report was provided to each site-specific Assessment Panel. The Independent Financial Adviser was also used to advise in relation to proposals by funding recipients for commercial borrowings.

## 4.5 The GP Super Clinics National Program Guide 2008

The *GP Super Clinics National Program Guide 2008*, which informed the Program for the first three years, was a key product of program implementation. In particular, it guided the processes for consultation and the separate Invitations to Apply (ITA) at all nominated GP Super Clinic localities. The *GP Super Clinics National Program Guide 2008* aimed "to give an overview of the national arrangements for the Program, as well as providing information on the funding potentially available and broad application processes".[2]

In its development, a version of this document, titled *GP Super Clinics Program Overview,* was provided as an "in-confidence draft for the purposes of consultation" to a large range of key primary health care stakeholder organisations for comment in January and February 2008, with a two-week response time. Individuals representing thirty-eight separate health organisations such as discipline-specific professional bodies, professional colleges, service network organisations, state health services and educational and training organisations were invited to comment on the draft overview document. Responses were received from thirty of these organisations. These responses were then publicly released on the Department of Health and Ageing website in April 2008, accompanied by a "Frequently Asked Questions" document. In light of comments from the consultation processes, and advice regarding funding and probity, this draft document was subsequently revised to become the *GP Super Clinics National Program Guide 2008*.

## 4.6 Evolution of the GP Super Clinics Program

There have been a number of developments in the GP Super Clinics Program which were noted from the document review and from interviews with Department of Health and Ageing staff. Many of these have been represented in updated editions of the Funding Agreement and the FAQs.

### 4.6.1 The GP Super Clinics National Program Guide 2008

The *GP Super Clinics National Program Guide 2008* applied to the clinics which were selected in the 2007-2008 tranche.[2] As the Program developed, the *GP Super Clinics National Program Guide 2008* was reviewed in the context of lessons learnt, with the subsequent publication of the *GP Super Clinics National Program Guide 2010*.[19] While it was evident that there was consistency between the two *Guides* in terms of the policy for the Program, there were a few key differences between the two documents which reflected learnings from the first tranche of GP Super Clinics with the 2010 *Guide* providing greater specificity of requirements.

### 4.6.2 Reporting Requirements

The reporting requirements have evolved over the course of the implementation and establishment aspects of the GP Super Clinics Program. The evolutions aimed to ensure that the reporting requirements in the establishment aspect more closely aligned to construction industry standards and that service arrangements during the business start-up phase were aligned with the GP Super Clinics Program objectives. Results in the establishment aspect of this evaluation reflect the need for even more evolution.

## 4.7 Invitation to Apply Processes

The invitation to apply (ITA) process to become a GP Super Clinic was described in the *GP Super Clinics National Program Guide 2008,* and notification about consultations occurred through direct contact, media and notices on the websites. The processes for each ITA and for assessment of applications were transparent and appeared to have complied with principles of sound public administration.

### 4.7.1 Consultation in GP Super Clinic Locations

Community consultations were undertaken in each of the identified GP Super Clinics locations, mainly but not exclusively through public forums.[2] The purpose of the consultations as articulated in the *GP Super Clinics National Program Guide 2008* was to:

- Share with the wider community the Commonwealth Government's intentions in investing in that community by establishing a GP Super Clinic
- Provide a forum at which the Commonwealth Government could gather the views of local health professionals and the wider community on the health needs and service priorities for the GP Super Clinic and also identify specific local issues that may impact on the implementation of the initiative
- Provide general information on application and funding processes for that particular GP Super Clinic locality
- Define, where applicable, what state or Territory contribution (if any) would also be available for that locality

In many instances, the Department also met directly with the AMA in conjunction with the public consultation. Other mechanisms for consultation included opportunities for feedback on the GP Super Clinics Program website, consultation with local Federal members and, where relevant, meetings with specific individuals. The public forums were supported by a DVD developed for these forums and a communication and consultation strategy. The key issues identified at each of the public forums were published on the Department of Health and Ageing website GP Super Clinics Section.

### 4.7.2 Assessment Panels for GP Super Clinics

Assessment panels were established for each of the GP Super Clinics localities. The panels were made up of experts with a range of skills relevant to the GP Super Clinics Program,

including a GP adviser on all assessment panels. The panels met to assess the applications resulting from the ITAs. Each panel received training, including training on issues related to probity in the process for assessment prior to the rating the applications. Comprehensive tools to support effective probity briefings were developed for consistency, and these have the potential to be used in similar grants programs. The assessment was based on capacity to achieve the GP Super Clinics Program objectives, the capacity of the proposed building to support the model of care, meet regulatory requirements and sustain financial viability, and on the use of information technology (IT).

### 4.8 Factors Impacting on the Implementation of the GP Super Clinics Program

A number of factors were identified as impacting either positively or negatively on the implementation of the GP Super Clinics Program 2007-2008. These factors were derived from document reviews and from interviews with Department of Health and Ageing staff.

**Ministerial and Departmental Commitment**

It was perceived and was obvious in documents such as Ministerial briefings and minutes that there was a high level of Ministerial commitment to the GP Super Clinics Program. This aligns with evidence cited in the document, *Implementation of Program and Policy Initiatives: Making Implementation Matter,* which stresses the importance of leadership and commitment.[25] This commitment was demonstrated through the approval processes at different levels of governance structures and through the locality-specific consultation processes. The commitment and leadership within the Division and Branch were also cited as positively impacting on implementation.

**Division and Branch Capacity**

There was no allocation within the budget for program implementation, i.e. the allocation of program staff is excluded in grants budgets. To address this, staff and funds were identified from other programs in the Primary and Ambulatory Care Division within the Department of Health and Ageing. This potentially compromised the adequacy of staffing in numbers, skills and experience, addressed the necessary start-up staffing levels, but did not address identified skills gaps.

The identification and filling of skills gaps was perceived to be an important factor in program implementation. The requirements for staff managing a grants program for construction and a new model of primary care were considerable. In addition to contracting specific expertise, a staff development program was tailored to train existing staff. This training is now part of the orientation program for all new GP Super Clinic Branch staff.

The complexities of managing large construction programs have been challenging for staff. The extensive consultation processes as part of the Invitation to Apply processes have also been demanding. The complexities of corporate structures commonly found in general practice have added to these challenges. Staff burnout was recognised as an issue which had the potential to impact on GP Super Clinics Branch operations.

The structure within the GP Super Clinics Branch has progressively evolved. It now facilitates vertical and horizontal integration across the executive team within the Branch. Executives have

diverse yet complementary skills for the nature of this Program. This was perceived to have positively impacted on the effectiveness of the Branch in managing the complexities of this grants program.

# 5 Establishment Aspect

Funding provided by the Australian Government for GP Super Clinics was used to purchase land and construct new buildings or to purchase or refurbish and/or extend existing buildings.[2] The exception was the ability for GP Super Clinics to apply to use a small amount of grant funding as 'recurrent funding' (following commencement of operations until the fourth anniversary of signing a funding agreement).[2] The specific items which were covered and excluded by the allocation of capital funding were outlined in the *GP Super Clinics National Program Guide 2008*.[2] The funding was provided against a set of milestones generally standard across all Funding Agreements (FAs) but with milestone dates specific to each GP Super Clinic. These milestones reflected the main phases of any construction project. Applicants were required to include key documents about the management of the construction with their applications.

Information relating to these milestones and the GP Super Clinics as originally proposed was obtained from desk reviews of documents provided by the GP Super Clinics Branch relating to each GP Super Clinic. In general, this documentation consisted of the original, executed FA and any subsequent Deeds of Variation (DoV) to those FAs. In two cases, Departmental files consisting of all related project communications and correspondence were provided. Access was provided to the comprehensive Project Plans setting out the development budgets, activity across timelines (mostly documented using Gant Charts) and construction programs for five of the GP Super Clinics.

The capital works component of the funding was managed separately from any other funding sources received by the successful applicants. The capital works proposal was expected to support the delivery of the services against the framework of the GP Super Clinics Program objectives.[2]

The capital component involved in most instances purchase of land, submission of development and building approval applications, design and documentation of the works, procurement of the builder, and construction. This required a number of separate and either sequential or concurrent steps from the land acquisition phase to construction completion.

## 5.1 Outcomes on Project Milestones

Assessment of the performance of the various projects against their respective project milestone dates has been carried out by reference to three sets of documents:

- The initial, executed FAs and any DoV
- The Departmental staff responses to the delay section of the survey
- The funding recipient responses to the delay section of the survey

There were divergences in opinion between Departmental staff and funding recipients as to whether or not delays had actually occurred, and if so, the causes of the delays. Although some of the significant discrepancies between the two sets of survey responses were resolved during

telephone interviews, in the final assessment a sizeable divergence remained between the two sets of responses.

Of thirty-six executed FAs inspected during the desk review, the timeline milestone dates for twenty-three had, at the time of the review in late September 2011, been varied by formal Deeds of Variation. Ten agreements had not been varied at the time of the review although two of these were still at very early stages of development. Three agreements had been varied because the initial FA did not specify milestone dates and the effect of the DoV was to incorporate these dates. It has been determined that one of the projects will not progress.

Departmental staff recorded delays to the anticipated completion dates for various stages of development of the projects for all but three of the clinics. As at the date of the survey, thirteen funding recipients claimed that there had been no delays to any stages of the projects. The views of the funding recipients as to the number of projects that were delayed by any cause (13) are matched by the number of formal DoVs issued by the Department for time-related matters.

### 5.2 Perspectives on Delays

Based on the results of the survey, Department staff reported 181 individual events of delay to the thirty-six sites for which survey results were obtained. In contrast, funding recipients acknowledged 82 events of delay to the thirty-three sites for which survey results were obtained. Three GP Super Clinics did not respond to this section of the surveys despite several approaches.

There was agreement about the number of delays that had affected a particular project on only 7 out of 33 instances, although a very close correlation on the number of delays was evident in a further two cases. The number of times a particular type of delay event had affected the progress of the projects was agreed to by Departmental staff and funding recipients on only 4 occasions out of 27, although there was close agreement (within a score of one) on a further four occasions.

Funding recipients in the telephone interviews were less inclined to acknowledge that a delay had occurred if the Department had subsequently granted an extension of time either to the particular Funding Agreement milestone date or to all subsequent milestone dates. In effect, the granting of an extension of time was perceived by the funding recipients as having extinguished the delay. In addition, where an extension of time was granted for a delay to a milestone date and this extension of time, as the consequence of a “knock-on effect”, resulted in an extension of all subsequent milestone dates, the Departmental survey responses recorded delays to each of those subsequent milestones, while funding recipients treated that delay as a single delay only.

Results in delays impacting on timelines reported by funding recipients and Departmental staff are reported in Table 2. Most delays to the 33 GP Super Clinics that completed surveys were recorded for events of delay during the land acquisition phase (23 events out of 82 or 28% of reported delays). These responses are largely consistent, in apportionment of cause of delay but not in numbers of delays, with responses from Departmental staff.

**Table 2: Numbers and Proportion of Delays Reported by Funding Recipients and Departmental Staff**

| Development Phase | Funding Recipients | | Departmental Staff | |
|---|---|---|---|---|
| | No. of Delays | Proportion of Delay Causes (%) | No. of Delays | Proportion of Delay Causes (%) |
| Land acquisition | 23 | 28 | 54 | 30 |
| Development application | 20 | 24 | 37 | 21 |
| Construction | 16 | 20 | 22 | 12 |
| Appointment of builder | 11 | 13 | 32 | 18 |
| Funding approval | 7 | 9 | 10 | 5 |
| Preparation of tender and construction documentation | 5 | 6 | 26 | 14 |
| Total | 82 | 100 | 181 | 100 |

This quantification of delays requires some qualification. Not all causes of delay were necessarily of the same gravity in terms of their impact on the overall progress of the projects. The simplified reduction of those survey results should not be read as an evaluation of their relative importance as a delay event because, at least up until commencement of construction, there are a number of concurrent "Critical Paths" for the developments, and delay in one of these paths may not necessarily translate to a delay in the overall progress of the works. For example, a delay in preparation of tender documentation or the appointment of the builder may not translate to a delay in the overall progress of the works if the concurrent approval of the DA was the more critical activity and it was not delayed. Conversely, delays in approval of funding might and have proved terminal for a project, eclipsing any concurrent delay in, for example, Development or Building Approvals.

## 5.3 Types of Delays

### 5.3.1 Land Acquisition

Land acquisition, if it was required as a part of the process of development of the GP Super Clinic, was usually described in FAs inspected during the desk review as "Funding recipient to provide evidence of finalised tenure over the land" milestone, or similar wording.

Twenty-three of the 33 sites required the acquisition of land, and all suffered some degree of delay. Only 11 funding recipients acknowledged acquisition delays, while Departmental staff believed 23 sites were delayed during this stage.

There were similar variances in opinion over the causes of delay, with funding recipients acknowledging 23 separate delay events and Departmental staff identifying 54 events.

### Council Approval of Sale

The steps involved in land purchase or acquisition by lease or strata are numerous and rely on a number of different individuals or organisations performing their roles in a timely way. Initially, a form of Contract of Sale has to be decided upon, usually by the seller or lessor in conjunction with their legal advisers. This form of contract has then to be agreed by the purchaser or lessee, usually in conjunction with their legal advisers. Depending on the funding arrangements for the acquisition, lawyers for funding organisations or equity partners may also be involved. As a general rule, the more parties involved, the longer each step will take.

There is also some evidence that the nature of the selling or purchasing organisation can influence the urgency with which the transaction is progressed. Large commercial corporations usually have several "layers" of management involved in the consideration and approval of these types of transactions, and may not always assign the same urgency to the transaction as the purchaser. In at least one instance, it was clear that the subdivision and sale of the portion of a site for the GP Super Clinic was not progressed through the seller's standard procedures as quickly as the funding recipient had hoped.

Both parties agreed that "Council approval of sale/transfer" was the greatest single cause of a delay event within the land acquisition phase, followed closely by "Late finalisation of the contract of sale" and "Late registration of the Title or Strata".

It is not possible from survey or telephone interview results to determine whether or not the root cause of the delay was over-ambitious expectations on the part of the funding recipient or tardiness on the part of Council or the approving authorities, as Councils and approving authorities were not surveyed or interviewed for the evaluation.

### Registration of Title

There has also been a tendency for funding recipients to act as though exchange of contracts for the sale, or execution of an Agreement to Lease, effectively secured not only the transaction but also all rights for them to act to establish the GP Super Clinics on the sites. Consequently, five funding recipients' responses to the survey identified "Late registration of Title or Strata" as the cause of delay. Again, because Councils or approving authorities were not surveyed, it is not possible to determine whether the approving authorities were tardy in processing the approval documents or whether the funding recipients simply misunderstood or incorrectly anticipated the time involved.

In one sense, the reasons why registration of Title or Strata was delayed is not the issue so much as whether the numerous steps that can be involved in this process were recognised early enough, and whether or not sufficient time was allowed in the projects for each step to occur. Depending on whether or not the transaction involves just a transfer of ownership of land or, for example, the subdivision and transfer of ownership, the timelines for completion can vary by a number of months.

### Subdivision of Land

Subdivision of land includes most the following processes:

- Surveys of the portion of land to be subdivided and the land that is left of the original title after subdivision are required. It is important that both surveys are carried out and processed concurrently because there will be new and modified titles created. These will both require preparation and some sort of registration of plans (e.g. Deposited Plans) by a registered surveyor

- Depending on the jurisdiction (local or state government) the process of registration of the surveys may be a Council activity or a State Department of Lands activity

- In some jurisdictions there are statutory minimum periods for the surveys to rest with the Chief Surveyor who signs them before they are registered. In some cases, public notification or gazettal is required before the plans are signed off, sometimes with statutory timeframes for the public notification. There may or may not be appeal rights associated with some of these processes.

- The act of subdivision is usually only completed when the signed survey plans are registered with Council or the State Lands Department at the end of this process.

Subdivision may also involve some construction activities or some secured, legal commitment to construction activities including:

- Provision of new sewer, stormwater, water and electrical services to the new site boundary (site servicing)

- Site contamination remediation (e.g. in the case of old service station sites)

- Construction of new roads and pedestrian and/or intersection works.

Council may require these to be completed as a pre-requisite to approval of the subdivision or some later step in the process of registration of Title. Subdivision to create a new site from an existing one can and did significantly extend acquisition timelines.

**Funding Delays**

Only one of the funding recipients surveyed assigned responsibility for “Delay in finalising the land acquisition” or “Late approval of funds for the purchase of the land” to Department delays, and only one identified the delays due to “Late bank approval of funding”.

### 5.3.2 Development Approval Processes

It is not possible, with any certainty, to anticipate times for development approvals. Qualified planning staff shortages, “blackout periods” at peak holiday periods, errors and omissions in public consultation notifications, scheduling of Council meetings and routine failures to distribute DA documents to other agencies and utilities in a timely manner are all reasons for unpredictable delays in processing and approval of development applications. Many Councils have taken to benchmarking themselves against other Councils on “number of days per approval” basis. This may serve as an indication of their historical performance in this area.

Most Councils and approving authorities are only “agents” for other authorities and utilities in the approval process. In particular, many Councils have subordinate roles to play with respect to State Main Roads and Environment Protection Departments. In this regard Councils are not in a position, and usually will not be drawn into a position, to provide opinions on what the other authorities may require as a condition of approval or how long it may take to obtain details of their requirements.

This milestone attracted the second highest recording of delays and events of delay. Funding recipients recorded 20 events of delay for the 33 GP Super Clinics and Departmental staff recorded 37 events. The most commonly reported event of delay by funding recipients was “New approval requirements imposed” (7 times) followed by “Design consultant documentation delay” (5 times) and “Council approval delays” (5 times).

Departmental staff responses to this section of the survey were heavily concentrated on “Other” causes of delay (16 times), followed closely by “Council approval delays” (11 times) and “New approval requirements imposed” (7 times). It is not possible to ascertain with any great accuracy the real reasons for the considerable delays during this phase, in the absence of surveys of Councils.

This phase is, however, arguably the least predictable in any private property development with regard to the timelines involved. It is also the least amenable to expedition because many of the requirements are statutory.

As is evident in the survey results, design consultants will often blame the shortcomings in their own performance on Councils and approving authorities. In several cases it is evident from some of the supplementary project information accessed for this evaluation that funding recipients, project managers and/or architects have failed to properly inform themselves of Councils’ requirements.

There is a tendency on the part of design professionals to take the most favourable views of Councils’ published requirements. They assume favourable outcomes in relation to timing will apply to their project if the contrary view will, in their or their client’s view, adversely affect the feasibility of the project. This is particularly so of parking requirements. From supplementary project information accessed on some of the projects, it is evident that delays occurred when funding recipients and their consultants first prepared parking plans. These plans were based on the most optimistic outcome, neglecting or declining to declare the optimistic assumptions to Council at DA submission stage. They then challenged the issue and, usually and almost always inevitably, redesigned the parking and the project to comply with the published Council requirements. In at least one instance it is clear that Council required the applicant to redesign the GP Super Clinic to reduce its size, and therefore the parking requirements it generated, as a condition of approval. In at least two cases it was necessary for the funding recipients to purchase additional land to meet the parking requirements.

It is not always possible to predict, regardless of how well the funding recipients or their professional consultants inform themselves, the additional information Councils and approving authorities may require before a DA submission is accepted for lodgement. Site contamination was cited in 3 instances as the reason for delays in approval of the DA, even though it was not clear, in the first instance, that any contamination existed. The mere risk that the site might be

contaminated was seen as sufficient grounds to withhold approval until significant (and expensive) site assessment was carried out.

Councils, funding recipients or their professional consultants cannot forecast the outcome of public consultation and notification processes now common place in most jurisdictions. In cases where re-zoning of land is required as part of the approval process, two separate and distinct public consultation and notification processes may apply to the one project on the one site: one to the re-zoning; and another to the Development Application. In many instances, re-zoning applications, which always attract longer timelines, have to be approved before the DA approval can take effect. Objections arising from public notification have in one instance, resulted in delay of over one year to a GP Super Clinic proposal, at virtually no cost or risk to the objector.

Some Councils have a practice of attaching completion of a range of infrastructure works to the conditions of approval of the DA Notices of Determination for even small- to medium-sized, complying developments. It is common for Councils to require these works to be either fully documented and approved by other agencies, or for the works themselves to be completed before the Development Approval for the new building works takes effect. The option to secure the undertaking of these works by lodgement of a cash deposit or bank guarantee for the value of the works was rarely investigated by the funding recipients. Development Approval Notices of Determination or Consent now routinely attach thirty to fifty pages to Conditions of Approval.

### 5.3.3 Funding Approval Processes

In survey responses, funding recipients for seven GP Super Clinics, slightly less than a quarter of all respondents, acknowledged delays at some stage due to funding problems. Departmental staff identified ten GP Super Clinics that were delayed by these problems.

The range of funding-related delays included the following: the design architect going into receivership; insufficient funds being available for the designs developed; and a shortfall in funding from other stakeholders. Only two of the 36 GP Super Clinics over 37 sites have not proceeded at the time of this report, principally because of problems sourcing additional funds. One of these will proceed after negotiations about funding arrangements are finalised.

### 5.3.4 Tender Documentation Processes

This type of delay scored lowest of all delay categories in both funding recipient and Departmental staff survey responses. Departmental staff rated “Other” causes of delay as contributing most to delays during this phase (13 of 26 or 50%) with “Client design changes” or “Client approval delays” accounting for a further eight of 26 (31%).

Funding recipients acknowledged far fewer events of delay during this phase (only five in total or less than 20% of those acknowledged by Departmental staff), while admitting to “Client design changes or Client approval delays” in two (40%) of these cases.

There were generally only regional variations in the responses to this section of the survey. All eastern states recorded acceptable performances to program by design consultants, and the largest delay recorded was in Western Australia. This delay was blamed by the funding recipient on the extraordinarily high design consultant workloads arising from the mining sector in that

state and the resultant shortage of skilled design resources. These are generally valid assessments of some of the design and documentation risks in this state.

### 5.3.5 Appointment of Builder

While the Departmental staff recorded high (13 out of 33 or 39%) "Other" causes of delay during this phase, both funding recipients and Departmental staff recorded significant delays (seven out of 32 and four out of 11 respectively) caused by "Late building approvals (BAs)."

From supplementary project information it is clear that there has been a relationship between the causes of delay during the most frequently delayed phase of development, the Development Approval or DA phase, and the BA phase. This is almost always due to the now common practice of Councils "carrying over" conditions of approval from DAs into BAs by imposing numerous "prior to commencement of construction" conditions in the DA Notices of Consent. As noted in section 5.3.2 of this report, conditions attached to the DA Notices of Consent for these projects now routinely run to thirty to fifty pages. Under these circumstances, private building certifiers responsible for issuing the BAs are obliged to enforce these conditions on the project on behalf of the Council.

Of the five projects identified by either the funding recipients or Departmental staff as having been delayed by tender results that were over budget, multiple tenders were received in four out of five cases. Bills of Quantities were provided to the tenderers in 4 out of 5 cases, and full design documentation was provided to them in four out of five cases. This suggests strongly that the project designs were over budget even before they were issued for tender and that all the processes normally employed to ensure competitive tender results did not overcome poor design management during documentation. It also suggests that the quantity surveyors, in preparing tender Bills of Quantities, did no more than measure the causes of the budget over-runs. These resources might have been better assigned to or supplemented by cost planning and cost control services.

### 5.3.6 Construction Completion

This phase of any development of construction projects is traditionally seen as one of the least predictable and most vulnerable to risk of extension of the various development phases. Neither funding recipients nor Departmental staff survey results support this view.

Once unavoidable causes of delay such as inclement weather are discounted from the survey results, the largest single contributory event during this phase (except for the "Other" category in the Departmental staff survey responses) was "Design change and variation delay".

Significantly, of the eight GP Super Clinic projects identified by funding recipients and Department staff as suffering delays to completion of construction due to Design Changes and Variations:

- seven out of eight did not incorporate the Department's recommended variation, delay and extension of time clauses in their construction contracts
- six out of eight had not provided the builders with a Bill of Quantities on which to tender

- four out of eight did not use the recommended Australian Standard 2124 (AS2124) form of contract

Conversely, six out of the eight had appointed a quantity surveyor (or independent project managers). It is not evident from any of the survey responses, at which stage in development of the design documentation these professionals were engaged. As a result it is not possible to determine whether they were in a position to exercise some control over these factors.

### 5.4 Building Construction for Delivery of Primary Care

The perceptions regarding whether the building design supported the delivery of primary care were sought at those GP Super Clinics which were providing services at the site visits as part of the operations aspects.

Most of the clinicians expressed satisfaction with the building in relation to the provision of primary care. However, most suggested that, in hind sight, changes could have been made. In particular, concerns about the distances between reception and waiting rooms were common despite different designs. A commonly expressed view was that there was a need for greater involvement of all disciplines in the design phase. Particular concerns in some GP Super Clinics related to widths of corridors representing wasted space, and giving the impression of hospital rather than primary care facilities.

Integration of disciplines within the buildings was uncommon, i.e. GPs tended to have a wing or section while other disciplines occupied other parts of the building. This was commonly perceived as a barrier to integration, especially by allied health and nursing staff.

### 5.5 Value for Money

Comparisons were made between the construction cost templates with the construction costs reported for of each of the GP Super Clinics that responded to the Establishment Aspect Survey.

Of the initial assessments of value for money all but six have been shown, to varying degrees, to represent acceptable value for money. Of these six, the construction cost for one was impacted by the need to remediate site contamination, a cost not provided for in the initial budgets. The construction cost for another is relatively high because of the added cost impost arising from the conversion of a heritage-listed building. A third site had an otherwise acceptable base building cost impacted by the delay costs that arose when construction was halted on two occasions. If these extra-ordinary circumstances had been factored into the value for money assessments, it is likely that they would have otherwise met the value for money criteria leaving three remaining sites as out of range of acceptable value for money.

The factors that contributed to the higher cost per square metre for the remaining three sites were not identifiable through the value for money assessment methodology and the advice obtained from the sites. It may well be that further assessment might identify similar extenuating circumstances but this would require further examination.

# 6 Operations Aspect

The GP Super Clinics Program objectives provide a framework for the model of care which was expected to be delivered by the GP Super Clinics.[2] While these objectives are not prescriptive it was expected that each GP Super Clinics demonstrate or progress strategies towards the elements described in the Program objectives.[2]

This component of the evaluation aimed to assess the extent to which these elements have been demonstrated from the perspectives of a range of stakeholders in each of the seven operational clinics. This chapter presents an overview of the sample of participants, key themes from analysis of interviews, results of surveys of patients and clinicians, and information collected in the self-assessment forms completed by GP Super Clinic Directors.

## 6.1 Overview of Participants

The following section provides an overview of participants for each of the evaluation methods for the operations aspects.

### 6.1.1 GP Super Clinic Directors

The self-assessment form was completed by six GP Super Clinic Directors. Fourteen Directors participated in the interviews at the site visit. This was greater than the number of GP Super Clinics (7) in this aspect of the evaluation, as some clinics had multiple Directors, some of whom actively chose to participate in interviews.

### 6.1.2 Patients

**Patient Survey**

Of the 1050 individuals invited to participate in the study, 710 provided data, with numbers per GP Super Clinic ranging from 9 to 146.

Table 3 provides socio-demographic characteristics of the sample. Almost two-thirds of the patients were female, and approximately half were aged 45 years or over, with 17% aged 65 or over. Fifty-nine percent were married or in a de facto relationship, and only 4% of the sample were Aboriginal or Torres Strait Islander. While 84% of the sample were born in Australia, 11% spoke a language other than English.

These data were compared to GP encounters with Bettering the Evaluation And Care of Health (BEACH) data. Relative to the population of general practice patients from BEACH data, the GP Super Clinics' patient sample had a slightly higher proportion of females, were younger, and had a higher proportion of Aboriginal and / or Torres Strait Islanders.[26]

**Table 3: Demographic Characteristics of Patient Participants in Survey**

| Patient Characteristic | Patient Survey Data | |
|---|---|---|
| | Number | Proportion of Sample (%) |
| **Gender** | | |
| Male | 253 | 36 |
| Female | 457 | 64 |
| **Age Group** | | |
| 18-24 | 73 | 10 |
| 25-34 | 134 | 19 |
| 35-44 | 141 | 20 |
| 45-54 | 140 | 20 |
| 55-64 | 95 | 13 |
| 65-74 | 67 | 9 |
| 75+ | 60 | 8 |
| **Relationship Status*** | | |
| Never married | 149 | 21 |
| Widowed | 42 | 6 |
| Divorced | 58 | 8 |
| Separated | 38 | 5 |
| Married (registered and de facto) | 417 | 59 |
| **Other Characteristics** | | |
| Aboriginal person | 31 | 4 |
| Non-English speaking background | 74 | 11 |
| Born in Australia | 593 | 84 |

* Data missing for 6 observations

Table 4 provides an overview of the employment status and health insurance characteristics of the patients who completed the survey in this evaluation.

**Table 4: Employment and Health Insurance Characteristics of Patient Participants in Survey**

| Patient Characteristic | Patient Survey Data | |
|---|---|---|
| | Number | Proportion of Sample (%) |
| **Employment Status** | | |
| Employed full-time | 273 | 38 |
| Employed part-time | 158 | 22 |
| Unemployed | 78 | 11 |
| Not in the labour force | 201 | 28 |
| **Health Insurance Characteristics** | | |
| Health Care, Veterans Affairs or Pensioner Concession Card | 172 | 24 |
| Private health insurance | 148 | 21 |
| No insurance or card | 389 | 55 |

Sixty percent of patients were in either full- or part-time employment. Over half of patients (55%) did not have either private insurance or a health concession card (Health Care Card, Pensioner Concession Card or Veterans Affairs Card).

An overview of the characteristics of patients completing the survey in relation to attendances at the GP Super Clinic is provided in Table 5.

**Table 5: Overview of GP Super Clinics Attendances of Patient Participants in Survey**

| Patient Characteristic | Patient Survey Data | |
|---|---|---|
| | Number | Proportion of Sample (%) |
| **Attendances** | | |
| Usual GP Practice | 645 | 91 |
| Changed from another practice | 343 | 52 |
| See GPs at another practice | 162 | 23 |
| Expecting to see usual doctor | 460 | 67 |
| **Clinicians other than GP seen in last year at GP Super Clinic** | | |
| Seen Nurse | 344 | 50 |
| Seen Allied health clinician | 188 | 27 |
| Seen medical specialist | 36 | 5 |
| **Frequency of Attending GP in Last Year*** | | |
| 1 time | 43 | 6 |
| 2-3 times | 166 | 24 |
| 4-5 times | 159 | 23 |
| 6-7 times | 113 | 16 |
| 8-9 times | 45 | 7 |
| More than 10 times | 165 | 24 |
| **Main Reason for Attending GP Super Clinics** | | |
| New problem | 164 | 24 |
| Existing or chronic problem | 221 | 32 |
| Work related problem | 18 | 3 |
| Treatment/procedure | 17 | 2 |
| Medication problem or prescription | 83 | 12 |
| Get results | 86 | 12 |
| General check up | 40 | 6 |
| Referral | 13 | 2 |
| Vaccination | 7 | 1 |
| Other | 42 | 6 |

* Contains Missing data

Six hundred and forty-five patients (91%) considered the GP Super Clinics as their usual GP practices. Of all patients who participated in the survey, 343 (52%) reported that they changed practice to attend the GP Super Clinics. Two-thirds of patients (67%) indicated that they were expecting to see their usual doctors at the visit. In relation to the other clinicians that patients had seen at the GP Super Clinics in the last twelve months, 50% had seen nurses, 27% had seen allied health clinicians and 5% had seen medical specialists.

Nearly one quarter (24%) of all patients reported attending the GP Super Clinics more than 10 times in the last twelve months. Twenty-four percent of patients were attending the GP Super Clinics on the day of survey completion for new problems, with 32% attending for existing or chronic problems.

### Patient Interviews

Twenty-four patients at the seven GP Super Clinics consented to participate in the semi-structured interviews. Of those patients interviewed, 75% were female, with age range from 25 to 78 years, and all but one patient had visited the GP Super Clinics a number of times.

### 6.1.3 Clinicians

#### Clinician Survey

Email addresses for 131 clinicians were provided by the GP Super Clinic Directors. Ten email addresses were automatically returned to the sender as being incorrect or "out of office" for the period of the web-based survey. A total of 53 clinicians completed the web-based survey, a response rate 44 per cent. The profile of the clinicians is outlined in Table 6.

**Table 6: Demographic Characteristics of Clinician Participants in Survey**

| Clinician Characteristic | Clinician Survey Data | |
|---|---|---|
| | Number | Proportion of Sample (%) |
| **Gender** | | |
| Male | 27 | 51 |
| Female | 26 | 49 |
| **Age** | | |
| 18-24 | 2 | 4 |
| 25-34 | 9 | 17 |
| 35-44 | 21 | 40 |
| 45-54 | 15 | 28 |
| 55-64 | 6 | 11 |
| 65+ | 0 | 0 |
| **Discipline** | | |
| General practitioner | 29 | 55 |
| PGPPP* | 1 | 2 |
| Non GP Medical specialist | 1 | 2 |
| Nurse | 4 | 8 |
| Psychologist | 7 | 13 |
| Physiotherapist | 4 | 8 |
| Podiatrist | 2 | 4 |
| Other allied health** | 4 | 8 |
| Manager | 1 | 2 |

* Prevocational General Practice Placements Program

** Other Allied Health includes Social Worker, Diabetes Educator, Dietician, and Occupational Therapist

Approximately equal proportions of male (51%) and female (49%) clinicians completed the clinician survey. The majority (68%, n=36) were between 35 and 54 years. Over half (55%, n=29) of the survey participants were GPs, four (8%) were nurses and 17 (33%) were allied health clinicians. The majority (75%) were employed on a contractual basis and 13% were employed by the GP Super Clinics.

#### Clinician Interviews

A total of 75 staff involved in management (including GP Super Clinic Directors) and clinicians from a range of disciplines, participated in the semi-structured interviews during the seven site visits. A discipline profile of the participating clinicians is outlined in Table 7.

**Table 7: Gender and Discipline Profile of Participants in Clinician Site-visit Interviews**

| | Clinician Interview Data | |
|---|---|---|
| **Discipline** | **Number** | **Proportion of Sample (%)** |
| General practitioner | 22 | 29 |
| Nurse | 13 | 17 |
| Psychologist | 4 | 5 |
| Dietician | 2 | 3 |
| Physiotherapist | 4 | 5 |
| Other allied health* | 5 | 7 |
| Managers** | 23 | 31 |
| Students (medical and nursing) | 2 | 3 |
| | 75 | 100 |

* Other included Occupational Therapist, Welfare, Social Worker, Exercise Physiologist and Podiatrist

** Included GP Super Clinic Directors, Practice Managers and Administrative staff managers

The majority of those interviewed were clinicians (66%) with managers (31%), and general practitioners (29%), nurses (17%) and allied health staff (20%) accounting for specific disciplines. GP Super Clinics Directors, who were GPs providing a clinical and management role, for the purposes of these data, were classified as managers. Similarly practice managers who were nurses and also provided a clinical role were classified as managers.

### 6.1.4 Community Stakeholders

Community stakeholders who were engaged in consultation with the GP Super Clinics and were identified in the Project Plans were contacted to participate in either a face-to-face or semi-structured interviews. Twenty-one community stakeholder names were provided and 11 participated in the interview. Of the 11, two were from another general practice, two were from a university, one was from a Division of General Practice, one was from an Aboriginal Community Controlled Health Service, two were Indigenous Elders, and three were from local state or non-government organisation health services.

## 6.2 Multi-disciplinary and Integrated Care

### 6.2.1 Multi-disciplinary Care

Older patients (>65 years) represented 17% of the patient survey sample with 32% (n= 221) of patients identifying as having a chronic illness. All GP Super Clinic Directors indicated when interviewed and through the self-assessment form that the GP Super Clinics were providing high quality multi-disciplinary care.

A total of 170 clinicians provided services at the six GP Super Clinics completing the self-assessment form; this equates to 94 full-time equivalents (FTEs). These numbers do not include information from one of the GP Super Clinics that did not complete the self-assessment form. An overview of the disciplines involved and their employment status (FTEs) is provided in Table 8. The GP Super Clinic which did not respond to the self-assessment survey reported 6 GPs providing services at the clinic.

Multi-disciplinary care occurred mainly through mechanisms such as the shared health record and the provision of multiple disciplines under one roof, thus facilitating referral, access and

communication about patient care. Access to Medicare Items such as those for Team Care Arrangements or Chronic Disease Management items was also identified as facilitating multi-disciplinary care. Care planning was mostly undertaken by a specific discipline such as a practice nurse or allied health staff, following assessment and clinical treatment advice by a GP. In most instances this occurred with the patient attending multiple appointments with the different disciplines.

**Table 8: Overview of Numbers and Employment Status of Clinicians***

| Clinician Characteristic | Clinician Interview Data | |
|---|---|---|
| | Number | FTEs |
| **Discipline** | | |
| General practitioner | 60 | 39 |
| Nurse | 32 | 20 |
| Psychologist | 13 | 6 |
| Dietician | 6 | 4 |
| Physiotherapist | 13 | 8 |
| Occupational therapist | 3 | 2 |
| Social worker | 3 | 3 |
| Podiatrist | 6 | 3 |
| Dentist | 1 | 1 |
| Non GP Medical specialist | 21 | 4 |
| Other | 12 | 4 |
| Total | 170 | 94 |

* Missing data from one clinic

Clinicians in interviews commonly reported that multi-disciplinary care was in place and was providing significant benefits for patients. Further, 83% of patients surveyed indicated agreement or a strong level of agreement that the reason they attended the GP Super Clinics was that they could see a range of other health professionals in the one location.

Table 9 reports the proportion of clinicians who rated elements of care as important or very important (Level 4 or 5), and the proportion who rated the same elements as extensively or fully implemented (Level 4 or 5). The elements of care are listed in the table in order of perceived decreasing level of importance.

The three elements of care ranked by the most participants as being important are Multi-disciplinary model of service delivery for people with chronic illness (96%; 95% CI 87%-100%), recruitment of a range of clinicians (94%; 95% CI 84%-99%) and preventative care (92%; 95% CI 82%-98%). These elements of care were considered to have been extensively or fully implemented by 87% (95% CI 75%-95%), 70% (95% CI 56%-82%) and 79% (95% CI 66%-89%) of clinicians respectively (ranked 3$^{rd}$, equal 4$^{th}$ and equal 5$^{th}$). Participation in research was ranked as least important (45%; 95% CI 32%-60%) and most poorly implemented (25%; 95% CI 14%-38%). After hours care was considered second least important element, but considered as being implemented reasonably well (62%; 95% CI 48%-75%).

While the extent of implementation was comparable to ratings of importance for multi-disciplinary model of care (87%), the proportions indicating extensive or full implementation for recruitment of a range of clinicians (70%) and preventative care (79%) was much less than

importance ratings. The biggest difference in ratings for importance (72%) compared to implementation (47%) was for training opportunities for clinicians.

**Table 9: Clinicians Ratings of Importance and Extent of Implementation of Key Elements of GP Super Clinics in Providing High Quality care**

| | Importance^ | | | Implementation# | | |
|---|---|---|---|---|---|---|
| | % | 95% Confidence Interval | | % | 95% Confidence Interval | |
| Multi-disciplinary model | 96 | 87 | 100 | 87 | 75 | 95 |
| Recruitment of a range of clinicians | 94 | 84 | 99 | 70 | 56 | 82 |
| Preventative care | 92 | 82 | 98 | 79 | 66 | 89 |
| Enhanced sharing of patient information | 89 | 77 | 96 | 91 | 79 | 97 |
| IT systems to support multi-disciplinary care | 87 | 75 | 95 | 89 | 77 | 96 |
| Retention of clinicians | 85 | 72 | 93 | 70 | 56 | 82 |
| Self-management for patients with chronic illness | 83 | 70 | 92 | 66 | 52 | 78 |
| Engagement with local community | 81 | 68 | 91 | 62 | 48 | 75 |
| Multi-disciplinary involvement in clinical governance | 79 | 66 | 89 | 64 | 50 | 77 |
| Multi-disciplinary involvement in development of service models | 79 | 66 | 89 | 55 | 40 | 68 |
| Meeting health needs of Aboriginal and Torres Strait Islanders | 74 | 60 | 85 | 60 | 46 | 74 |
| Physical infrastructure to support training | 74 | 60 | 85 | 79 | 66 | 89 |
| Training (professional development) opportunities for clinicians | 72 | 58 | 83 | 47 | 33 | 61 |
| Shared planning with external health services | 70 | 56 | 82 | 55 | 40 | 68 |
| Training opportunities in multi-disciplinary care | 70 | 56 | 82 | 55 | 40 | 68 |
| Meeting health needs of older Australians | 64 | 50 | 77 | 70 | 56 | 82 |
| Multi-disciplinary involvement in organisational governance | 64 | 50 | 77 | 57 | 42 | 70 |
| After-hours care | 58 | 44 | 72 | 62 | 48 | 75 |
| Participation in research | 45 | 32 | 60 | 25 | 14 | 38 |

^ Percentage of clinicians who rated this aspect as importance level 4 or 5

# Percentage of clinicians who rated this aspect as being implemented at level 4 or 5

Clinicians were asked about their perceptions about factors which support multi-disciplinary care at their GP Super Clinics (Table 10).

**Table 10: Clinicians' Perception of Factors which Support Multi-disciplinary Care**

| | %^ | 95 % Confidence Interval | |
|---|---|---|---|
| Management commitment | 94 | 84 | 99 |
| Respect for the contribution of all disciplines | 94 | 84 | 99 |
| Communication systems within this GP Super Clinic | 94 | 84 | 99 |
| IT systems | 94 | 84 | 99 |
| Clinical protocols and guidelines | 91 | 79 | 97 |
| Clinical leadership from all clinical leaders | 85 | 72 | 93 |
| Data collection systems which support understanding of performance and outcomes | 79 | 66 | 89 |
| Time availability for provision of multi-disciplinary care planning | 79 | 66 | 89 |
| Funding for all aspects of multi-disciplinary care | 75 | 62 | 86 |
| Processes for involvement of all disciplines in clinical governance approaches | 74 | 60 | 85 |
| Processes for involvement of all disciplines in organisational governance approaches | 64 | 50 | 77 |

^ Percentage of clinician agreeing or strongly agreeing that the factors support multi-disciplinary care at this GP Super Clinic

Management commitment, respect for the contribution of all disciplines, communication systems within the GP Super Clinics and IT systems were all considered by almost all clinicians to support multidisciplinary care at GP Super Clinics (94%; 95% CI 84%-99%). The factor considered by the least number of clinicians as supporting multi-disciplinary care in the GP Super Clinics was processes for involvement of all disciplines in organisational governance approaches (64%; 95% CI 50%-77%).

### 6.2.2 Integrated Care

All of the GP Super Clinics Directors demonstrated awareness of the importance of ensuring care was integrated across aspects of their service delivery model. They indicated that they had achieved extensive or full implementation of integrated care within their practices. However, most indicated that the integration within the GP Super Clinics was more reliant on corridor conversations and on shared health records, than on more systematic approaches supported by multi-disciplinary clinical guidelines.

Of the patients completing the survey, 66% agreed or strongly agreed that the GP Super Clinic staff coordinated all aspects of their care. These data suggest the majority of patients believe that their care is well-integrated within the GP Super Clinics.

### 6.2.3 Factors Impacting on Provision of Multi-disciplinary and Integrated Care

Clinicians indicated a number of factors either positively or negatively impacted on the provision of multi-disciplinary and integrated care within the GP Super Clinics. First, clinical and

organisational leadership which provided direction and support was considered critical in driving the model of care. In most interviews this was reflected in comments by GP Super Clinic Directors and clinicians. This reflects evidence of the importance of clinical and organisational leadership in most clinical settings.[27,28] Many clinicians indicated that the Directors had a clear vision of the model of care which drove a range of strategies to support the model. In GP Super Clinics where this leadership was less evident or where there was uncertainty in the clinical leadership roles, the model of multi-disciplinary care appeared to be one dependent on co-location of disciplines and on a "business as usual approach" rather than a vision of integrated multi-disciplinary teams..

Second, the model of care where multiple disciplines provide care under one roof, was considered critical to the success of the GP Super Clinics. This enabled access to and immediacy of information-sharing among different disciplines which, under other models, were reliant on varying forms of communication between disciplines. Most clinicians were positive about co-location.

> I have worked in a private practice before with other [allied health disciplines]. I had little communication with GPs other than through referrals or summaries of interventions. I did not know many of them [GPs] other than at the end of a phone. Here I can catch them in the corridor to discuss a client, as well as having the shared health record. It works brilliantly and I think the clients are getting better care because of these informal corridor conversations."
> Allied health professional – interview

This was further reflected in patient comments in surveys and in interviews.

> ....This practice offers a range of services all in the one place
> Patient - survey
>
> [Moved to this GP Super Clinic] Because of the multi-disciplinary service this clinic gives
> Patient - survey
>
> We moved here to be near this clinic. It has a range of service which [spouse] needs and they are all here in one spot. So we don't have to travel to different spots. And they all know what's going on with [spouse] as it is all on the record.
> Patient - interview

Third, the shared health record was seen by clinicians as a key factor in enabling the sharing of information to support multi-disciplinary care. The record was seen as an efficient and effective tool which resulted in better care for patients. In particular, allied health clinicians commented on the importance of the shared health record in supporting coordination of care, a system which they had not experienced when working in separate locations. The majority of clinicians (88%) in the survey rated IT systems to support multi-disciplinary care as important, with 89% indicating that such IT was in place in their GP Super Clinic. This was reinforced by many patients who indicated that they were happy with the shared health record as it meant that all the clinicians were aware of their clinical information and they did not have to repeat the information when seeing a range of clinicians at the GP Super Clinics.

Fourth, the culture of and team-work within most of the GP Super Clinics were conducive to multi-disciplinary care. Evidence for factors impacting on teamwork in relation to multi-

disciplinary care align with elements of the model within the GP Super Clinics, such as co-location and shared electronic health records.[29] However, evidence also supports the need for shared planning and protocols. The extent to which these were effectively in place in most GP Super Clinics was not able to be determined accurately. To maintain a positive culture and team-work, more attention to shared planning and protocols may be required.

Fifth, the differences in organisational models including not-for-profit, community owned, private for profit and third party contractual arrangements, did not appear to impact on the provision of multi-disciplinary and integrated care. Rather the flexibility in models provided for under the GP Super Clinics Program allowed resources to be used to suit local needs and contexts. Problems in relation to organisational models occurred where there were third party contractual arrangements requiring reporting at multiple levels and attempts to align sometimes disparate objectives.

Lastly, access to and equity in the Medicare Benefits Schedule (MBS) was raised consistently as a barrier to optimising multi-disciplinary care. In particular, clinicians raised the inconsistency in access for all disciplines and the inequity in remuneration across disciplines for participating in multi-disciplinary teams and in particular for case management. The MBS items 735 to 758 provide rebates for medical practitioners (not including specialists or consultant physicians) to organise and coordinate, or participate in, multi-disciplinary case conferences for patients in the community or patients being discharged into the community from hospital, or people living in residential aged care facilities.[30] These items were recognised as supporting some aspects of multi-disciplinary care but the inequity in remuneration was perceived to be a barrier.

GP Super Clinics doctors frequently identified a feeling of guilt in case management as they were able to bill for these services, whereas allied health were unable to bill under the MBS item. In many instances, allied health staff reported willingness to participate in case conferences in the interest of patient care and their professional learning.

### 6.2.4 Clinical Governance

The inclusion of clinical governance aimed to enhance quality as part of the multi-disciplinary approach to care. Clinical governance in acute settings has traditionally focused on monitoring and addressing adverse events and risks.

Approaches to clinical governance in the GP Super Clinics were variable at best with some clinics formalising approaches to clinical governance through policies, clinical protocols and mechanisms such as clinical review meetings. Only one of the GP Super Clinic Directors reported full implementation of formal clinical governance approaches. Only one of the Directors reported involvement of multiple disciplines in clinical governance. This was aligned to views of clinicians who reported less than optimal approaches to clinical governance, and in particular, multi-disciplinary involvement.

The majority of clinicians (79%) rated multi-disciplinary involvement in clinical governance as important. However, only 64% of clinicians indicated that this had been fully implemented. In contrast, a number of the GP Super Clinics appeared to have a more informal and reactive approach which included dealing with issues as they arose.

### 6.2.5 Self-management

Self-management is an important approach to supporting patients with chronic and complex conditions.[31] All Directors reported extensive or full implementation of self-management approaches. Clinicians mostly reported that they included self-management approaches to patient care as part of consultations. In addition, some clinicians provided specific self-management programs. The extent of planned approaches to self-management as part of care coordination, apart from where specific group programs were run, was not as evident. Almost two-thirds of patients (65%) indicated that their GPs or other health professionals discussed with them ways of better managing their health.

## 6.3 Responsiveness to Local Community

Most GP Super Clinics reported using processes, usually including consultation, to determine community needs. This occurred most commonly in the phase leading up to the construction of the GP Super Clinics. Examples were provided of engagement with community members, Divisions of General Practice, aged care facilities and Aboriginal Medical Services.

One GP Super Clinic reported specific engagement approaches with members of the Aboriginal community in the local area. This was not a formal consultation strategy. Rather, it was an attempt to meet and get to know members of the Aboriginal community and build relationships that would support Aboriginal engagement. This has been ongoing, and there was evidence of significant impact, with 600 patients identifying as Aboriginal at this one GP Super Clinic. This approach has been further supported by participation in the Australian Government's Closing the Gap Collaborative.

> [Director] came and met me a few years ago to talk about what he wanted to do and asked what we needed. We still talk regularly. Everything he committed to he has done..... We meet regularly and the word has got around about this clinic. Indigenous people here get great service.
>
> Indigenous Elder - interview

Another GP Super Clinic provided examples of engagement with the local Aboriginal community through Elders and the Aboriginal Medical Service. As a result, programs targeting local Aboriginal young people have been developed.

Many of the community stakeholders reported positive experiences in relation to the engagement processes with the GP Super Clinic Directors in the early phase of development. Some had developed clinical relationships with the GP Super Clinic since their inception.

The extent of ongoing involvement in part depended on the organisational structure of the GP Super Clinics. Where Boards existed, members had often been involved in engagement in the early phases of the GP Super Clinics. While Board membership was mostly skills-based this was viewed as important in the GP Super Clinics' infancy. As a consequence, the members did not necessarily reflect community views. Rather, they brought specific and needed skills to the Boards for the stage of development of the GP Super Clinics.

## 6.4 Accessible Primary Health Care

Access to primary health care is fundamental to a high-performing health system.[9] Ability to get appointments and financial costs associated with reduced bulk billing rates have been cited in many studies in Australia as barriers to access to primary care.[9]

All GP Super Clinic Directors had some arrangements for either extended or after-hours medical care. The format this took depended on perceived demand and other local arrangements, such as advising patients of the GP Super Clinic's arrangement with an agreed after-hours provider. Where extended and after-hours care was provided, demand was mostly seen as greatest between 6.00 p.m. and 10.00 p.m. Some GP Super Clinics had successfully provided weekend clinics. Some GP Super Clinics provided and others were examining the opportunities for out-of-normal-hours allied health appointments.

Just over half (58%) of clinicians indicated that the provision of after-hours care was important. Some clinicians perceived that demand for after-hours care had decreased because of greater availability of appointments during normal business hours. This aligned with the views of some patients who indicated they could access appointments without having to wait for weeks.

> At [previous] clinic I had to wait for about a week to get an appointment. If urgent, you had to try to the local after-hours which wasn't great. Here I can usually get an appointment within a day.

In the survey, just over half of all patients (52%) reported they had changed from another practice to attend the GP Super Clinics. Results from the survey also indicated that patients rated access issues regarding availability and costs as important determinants of reasons to attend the GP Super Clinics. The majority (67%) of the patients participating in the survey also indicated that they were there on the day to see their usual doctors.

Table 11 describes the reasons patients report attending the GP Super Clinics, defined as the proportion strongly agreeing or agreeing with each statement. These are presented in decreasing order, with the most commonly specified reasons reported first.

**Table 11: Percentage of Patients Agreeing with Reasons for Attending GP Super Clinic***

| Reason for attending | Percentage Agreeing* | 95% Confidence Interval[&] | | Design Effect |
|---|---|---|---|---|
| Hours clinic opens suits need | 87 | 81 | 92 | 2.9 |
| Close to home/work | 85 | 76 | 90 | 4.2 |
| See range of health professionals | 83 | 74 | 90 | 5.3 |
| Access to GP of choice | 79 | 64 | 89 | 11.3 |
| Clinic bulk bills | 75 | 52 | 89 | 22.9 |
| Staff understand health needs | 72 | 58 | 83 | 8.5 |
| Staff communicate well with external providers | 68 | 53 | 80 | 10.2 |
| Clinic coordinates all aspects of care | 66 | 51 | 78 | 9.9 |
| Do not wait more than 1 day for appointment | 65 | 52 | 77 | 8.3 |
| Staff understand cultural needs | 57 | 44 | 70 | 8.2 |
| After hours services available | 52 | 38 | 65 | 9.0 |

| Reason for attending | Percentage Agreeing* | 95% Confidence Interval[&] | | Design Effect |
|---|---|---|---|---|
| Drop in appointments available | 42 | 30 | 55 | 7.8 |
| Can't get appointment at other practice | 30 | 21 | 41 | 5.1 |

* Percentage agreeing or strongly agreeing with each reason

& Standard error adjusted for correlation of patients within clinics using the jack-knife method for the survey tabulate option in Stata

The three most commonly cited reasons for attendance at the GP Super Clinics were: the suitability of the GP Super Clinics opening hours (87%; 95% CI 81%-92%), although only half of the patients (52%; 95% CI 38%-65%) considered after hours opening as important; the location of the GP Super Clinics, i.e. that is they were close to the patients' home or work (85%; 95% CI 76%-90%); and that patients could see a range of health professionals within the same location (83%; 95% CI 74%-89%).

The opportunity to see the GP of their choice, the fact that the GP Super Clinics bulk-billed and the fact that the staff understand the patients' health needs were also rated highly by 79% (95% CI 64%-89%), 75% (95% CI 52%-89%) and 72% (95% CI 58%-83%) of patients respectively.

The least important reasons for attending the GP Super Clinic were that it offered drop-in appointments (42%; 95% CI 30%-55%) or because the patient could not get an appointment at another local GP clinic (30%; 95% CI 21%-41%).

The design effects for reasons for attendance ranged from 2.9 for clinic opening hours to 22.9 for bulk-billing. The high value for bulk-billing is not unexpected given that this is a GP Super Clinic feature, i.e. although the importance of this may vary among patients within the same GP Super Clinic, whether or not patients are bulk-billed is determined at the clinic level.

Many patients made comments in the survey as to the reasons for changing to the GP Super Clinics with most providing multiple reasons. These comments were coded with the top six reasons patients changed from another practice reported in Table 12.

**Table 12: Top Six Reasons for Changing to the GP Super Clinic – Survey Comments**

| Reasons | Number of Mentions |
|---|---|
| Access to appointments | 64 |
| Quality of care | 62 |
| Convenience of location | 59 |
| Moved to area | 52 |
| Followed a GP | 50 |
| Cost | 50 |

The reasons for changing were made in either a positive or negative sense. For example, reasons such as "easier to get an appointment" or "had to wait weeks to get an appointment at other clinic" were both coded as access to appointments. Similarly, comments such as "heard the doctors here provide good care" and "dissatisfied with quality of care at other clinic" were both coded as quality of care. Availability of appointments was the most common reason for changing practice, with 64 mentions, followed by those about quality of care (62 mentions) and

convenience of location (59 mentions). Comments from surveyed patients about reasons for change, such as those outlined below, were common.

**Patient Comments – Reasons for Change – Patient Survey**

"Quicker access to doctors. Unsatisfied with medical care. Unsatisfied with attitudes of reception staff"

"Doctor more professional and get appointment most of time"

"I lost confidence in the doctor and was too expensive"

"More availability plus all services under one roof"

These results corresponded to common themes in patient interviews, where these were the top reasons for moving to the GP Super Clinics. In particular, during interviews patients reported that wait times of up to two weeks were not uncommon at previous practices and expressed frustration about lack of availability of appointments even when they were sick. Concerns about the quality of care as reasons for changing clinics were also common in patient interviews.

All GP Super Clinics provided bulk-billing for some of their patients. Mostly, this was for children less than 16 years, and pensioners and/or people with health concession cards. In one GP Super Clinic all patients were bulk-billed. While it was acknowledged that bulk-billing was desirable, most espoused the view that financial viability was impossible with total bulk-billing. Allied health disciplines seeing clients under MBS-rebatable items bulk-billed in line with GP Super Clinic arrangements. This had in most instances been negotiated as part of the contract for service engagement.

Cultural appropriateness is also an important element of access. Two of the GP Super Clinics had participated in the national Closing Gap the Gap Primary Care Collaborative. A further two GP Super Clinics had undertaken specific training for staff, including reception staff, with respect to cultural appropriateness for Aboriginal and Torres Strait Islander peoples. The majority of patients (57%) indicated that the GP Super Clinics met their cultural needs. The focus on cultural appropriateness as an important element of access appeared to be related to the commitment of the GP Super Clinic Directors to rate this as important. This was evident in GP Super Clinics which had participated in the Closing the Gap Collaboratives. However, these were in the minority, and greater engagement of Aboriginal people and where relevant, refugee or other Culturally and Linguistically Diverse (CALD) groups could be considered in GP Super Clinics in the future.

### 6.5 Preventative Care

In interviews, when asked about their role in preventative health care, most clinicians reported activities related to chronic disease management. It was only when prompted about their role in primary prevention, preventative health care in patients with risk factors but without disease, that they considered other strategies.

Table 13 reports the percentage of patients in the surveys reporting that their clinicians either sometimes or always discussed aspects of preventative care with them.

**Table 13: Percentage Patients Reporting Discussion with Clinicians about Preventative Care**

| Reason for attending[#] | Percentage agreeing* % | 95% confidence interval[&] % | | Design Effect |
|---|---|---|---|---|
| Discussion about lifestyle risks | 59 | 48 | 69 | 5.2 |
| Advice about changing lifestyle risks | 55 | 40 | 69 | 9.7 |
| Advice about better management of health | 65 | 49 | 78 | 10.6 |

* Percentage reporting issue sometimes or always discussed

# Reasons are not mutually exclusive

& Standard error adjusted for correlation of patients within clinics using the jack-knife method option of the survey tabulate command in Stata

Less than two-thirds of patients reported that their GPs or health care workers discussed any of the specified aspects of health or health care, such as ways of managing their health (65%; 95% CI 49%-78%), lifestyle risks (59%; 95% CI 48%-69%) and advice about changing lifestyle risks (55%; 95% CI 40%-69%). In comparison, in another Australian study focusing on prevention advice about obesity, only one-third of over-weight or obese patients recalled receiving dietary and/or exercise advice from their GPs in the past 12 months.[32]

Clinicians were asked the same questions in relation to preventative care. Table 14 reports the results from these questions for clinicians.

**Table 14: Percentage Clinicians Reporting Discussion with Patients about Preventative Care**

| | Percentage agreeing ^ % | 95 % Confidence Interval | |
|---|---|---|---|
| Lifestyle risks (e.g. smoking) that might impact on their health | 98 | 89 | 100 |
| Advice about changing lifestyle risks (like doing more exercise) | 98 | 89 | 100 |
| How to better self-manage their health conditions | 98 | 89 | 100 |

^ Percentage of clinician who reported sometimes or always discussing each aspect of health care

Most clinicians reported that they sometimes or always discussed with their patients lifestyle risks, advice about changing lifestyle risks and how to better manage their health conditions (98%, 95% CI 89%-100% for all aspect of preventive care). Patient report of these discussion was much lower: with 65% reporting that their GP or health worker provided advice about better management of their health; 59% reporting receiving discussion and 55% reporting advice about lifestyle risks was lower than the proportion of health workers reporting discussing those aspects of care.

## 6.6 Effective Use of Information Technology

The seven GP Super Clinics used electronic health record products for access by all clinicians, subject to agreed permission levels. All seven GP Super Clinics were consistent in their approach to compliance with privacy regulations for shared electronic health records. Most had privacy policies and had provided staff training in confidentiality. These policies were usually aligned with requirements under the accreditation process. The majority of GP Super Clinics had permission levels for discipline type in relation to sharing of information. These were most commonly applied for psychologists and/or social workers.

All GP Super Clinics had some type of consent form for patients for sharing of records: these mostly included opportunities for exclusion of sharing. The majority of patients interviewed indicated the use of electronic health records as positive. None of the patients expressed concern about sharing of records. Rather, the majority perceived that it was valuable when they saw another clinician in the practice that access to their history was available.

> Sometimes I see another doctor. My records are all on the computer so I don't have to repeat everything about me – they can just access it.
>
> Patient - Interview

None of the GP Super Clinics had implemented systems for sharing of electronic health records with external health care providers. However, two had indicated that plans were in place to trial an approach of shared electronic records with an external provider, in both instances with an aged care facility. The GP Super Clinic Directors indicated that the planning and processes required for this to occur were time-consuming to ensure both accuracy in shared information and compliance with privacy regulations.

## 6.7 Recruiting and Retaining the Primary Care Workforce

### Net Increase in Access to GPs in Local Areas

To date across these seven GP Super Clinics, it is estimated that there has been a net increase of 19 GPs. This figure is derived from the total number of GPs at each of the GP Super Clinics, minus the number of GPs reported by the Directors as having moved from a local practice.

### Model of Care

Most of the GPs interviewed indicated that the models of care applied in the GP Super Clinics was a major factor in retention. In particular, many GPs indicated that the delineation of duties within the practices allowed them to focus on "their medical work" and allowed other disciplines to undertake other aspects of primary care such as chronic disease management. This aligns with evidence from the United Kingdom where GPs reported positive experiences with the delineation of workloads among disciplines, enabling them to focus on more complex patients.[33]

> "I feel this is what I have been trained for. I can efficiently use my medical skills....and allow others such as the Chronic Disease Nurse to spend more time in developing and monitoring care plans....Working under this model is the most professionally fulfilled that I have been."
> GP - Interview

Clinicians were asked in the survey to indicate their levels of agreement with reasons for working in the GP Super Clinic (Table 15).

**Table 15: Percentage of Clinicians Reporting Reasons for Working at GP Super Clinics**

| | %^ | 95 % Confidence Interval | |
|---|---|---|---|
| Commitment to provision of integrated care | 92 | 82 | 98 |
| Commitment to the provision of multi-disciplinary care | 89 | 77 | 96 |
| Opportunity to work with a range of disciplines | 87 | 75 | 95 |
| Strong approach to ensuring and monitoring quality | 81 | 68 | 91 |
| Service models meet the health needs of the community | 77 | 64 | 88 |
| Commitment to supporting and retaining staff | 75 | 62 | 86 |
| Multidisciplinary involvement in clinical governance | 70 | 56 | 82 |
| Flexible hours | 68 | 54 | 80 |
| Opportunity to participate in teaching/training of students/new graduates | 57 | 42 | 70 |
| Multidisciplinary involvement in organisational governance | 57 | 42 | 70 |
| Opportunity to participate in research | 26 | 15 | 40 |

^ Percentage of clinician agreeing or strongly agreeing with each reason for working in clinic

The most important reason for participants working at the GP Super Clinics was commitment to provision of integrated care (92%; 95% CI 82%-98%), followed by commitment to provision of multidisciplinary care (89%; 95% CI 77%-96%) and opportunity to work with a range of disciplines (87%; 95% CI 75%-95%). The opportunity to participate in research was considered to be the least important reason for working at the GP Super Clinics (26%; 95% CI 15%-40%).

**Teaching and Training**

Many of the clinicians interviewed indicated that the opportunity for participating in teaching and training was a facilitator in commencing and maintaining their positions in the GP Super Clinics. This appeared to be related to a philosophical commitment to teaching and training, and the capacity to influence future graduates in their particular disciplines in the model of care. In addition, the inclusion of suitable space was a factor in their willingness and capacity to provide training.

There was a common perception that the model under which students and graduates would be trained at the GP Super Clinics would be substantially different from that experienced in other practices where clinicians had worked. In particular, it was expected but not totally realised that the opportunities for partnership approaches to teaching and training would be available in GP Super Clinics. In this way the GP Super Clinics could provide placements under a multi-disciplinary model and universities in return could align their teaching programs with this model of care.

**Business Model and Financial Viability**

The majority of GPs and other clinicians provided services at the GP Super Clinics under a contract based on a negotiated proportion of all patient-derived income. The majority of GPs interviewed indicated that the business model was a key element in their recruitment and retention. While not all indicated that the financial viability was optimal, they were positive that this would be reached within time. The business model allowed them to develop a sense of autonomy, albeit within a care team which provided the necessary clinical support.

A number of the GPs indicated that they had left profit-driven corporate models of General Practice where they perceived that salary differentials were inequitable and the model of care did not reflect their expectations for high quality primary care. In these instances, GPs expressed views that GP Super Clinics provided a balance between financial viability and their beliefs about high quality care which was not available in the corporate models in which they had worked.

Administrative support provided by the GP Super Clinics was also a factor in recruitment and retention. This was provided as part of the contractual arrangements for the clinicians. It was perceived as representing value-for-money for clinicians and ensured they could focus on clinical rather than administrative duties. Indeed, some who had been in practice as sole practitioners and/or business owners indicated that the administrative load in private practice was a factor in their decisions to seek alternative arrangements.

**Misinformation**

One issue which was unexpectedly raised as a barrier to recruitment, but not to retention, was the misinformation and adverse media coverage about GP Super Clinics at start-up. Many of the GP Super Clinic Directors reported they spent significant time, especially in the early stages, countering misinformation in the media and among the community about GP Super Clinics and the models of care. A number of clinicians also reported their initial concerns about commencing at the GP Super Clinics, given the negative media coverage. Indeed, some clinicians at a number of sites reported active campaigns run locally against GP Super Clinics, and the clinicians, usually by other doctors. This was perceived as due to threats about the GP Super Clinics providing unfair competition locally, in spite of many patients who indicated a reason for changing to the GP Super Clinics was inability to get timely appointments at other clinics.

The situation was reinforced by some patients indicating an initial feeling of wariness about the GP Super Clinics, given negative local media coverage. However, patients who raised this also indicated that their experiences at the GP Super Clinics differed from their expectations.

> I'd read in the [local paper] about the clinic....I thought it was going to be like a big production factory....But after coming here now a few times it could not be further from the truth. I can get an appointment where at [previous clinic] I had to wait weeks. I can usually see a doctor that I want to see. Everyone is friendly. The service is much better...you are actually treated like a person, not a number. This is so what this area needed and I am not sure what all the fuss was about.
>
> Patient - Interview

Some GP Super Clinic Directors also reported that they were now receiving calls from GPs expressing interest in working at the GP Super Clinic. Most commonly, the Directors reported

that the interest of these GPs was based on a desire to work under the model of multi-disciplinary care provided at the GP Super Clinics.

### 6.8 High Quality Best Practice Care

Approaches to high quality best practice care in the seven GP Super Clinics were evident. Most of these related to quality improvement approaches such as collaboratives or quality assessment approaches such as through accreditation. Patient satisfaction surveys and data collection in the context of specific collaboratives had also been undertaken.

All of the GP Super Clinics had participated or were about to participate in accreditation processes. A number of GP Super Clinics cited participation in a number of accreditation processes beyond systems such as Australian General Practice Accreditation Limited (AGPAL). Training practices are accredited according to Royal Australian College of General Practitioners (RACGP), and the Australian College of Rural and Remote Medicine (ACRRM) standards, depending on location and range of experiences available for GP Registrars.

All GP Super Clinics had developed or adapted clinical policy and protocols for some conditions with reliance on RACGP guidelines. These guidelines may be clinically appropriate for general practitioners but do not always reflect the multi-disciplinary care model applied by the GP Super Clinics.

Some of the GP Super Clinics have participated in the national Primary Care Collaboratives. Two GP Super Clinics reported participation in the *Closing the Gap - Improving Indigenous Access to Mainstream Primary Care Program*. Another GP Super Clinic had participated in a Diabetes Primary Care Collaborative. Other local initiatives evident in most GP Super Clinics were clinical meetings and clinical review meetings.

Aligned with evidence, approaches to quality in general practice tend to be project-based.[34] There was limited evidence of the extent to which these were embedded as part of the culture of the workforce in the GP Super Clinics. Delivering high-quality care in a multi-disciplinary environment requires new models of shared care to be developed in collaboration with a range of disciplines within and external to the GP Super Clinics. It was common for GP Super Clinics to adopt but not tailor RACGP clinical guidelines to their settings regardless of the context in which they provided services. Given that these do not necessarily reflect the evidence of multiple disciplines, their relevance could be questioned and ownership, and hence compliance by disciplines, reduced

Barriers to embedding approaches to quality identified through interviews with clinicians were numerous. First, in this early stage of maturation, the priorities of the GP Super Clinics were on other issues. This is not to say there was not a commitment to quality, with numerous examples provided. However, it was evident that other organisational priorities had been addressed. Second and related to the first barrier of relative priorities, is that embedding quality as part of the culture requires leadership, which at this stage had been directed towards other priorities in the GP Super Clinics. Third, it was evident that the knowledge of and skills in approaches to embedding quality was at best variable. Last, as identified in the evidence, in the absence of a systematic approach to quality across the primary care sector, approaches to quality which measure and allow comparison of performance are not possible.

### 6.9 Viable, Sustainable and Efficient Business Models

All GP Super Clinics had a strong focus on the viability and sustainability of business models. While not all GP Super Clinics were presently financially viable, most indicated they were optimistic about achieving this within the first three years of operation. In the main, the approach to achieving viability was a combination of MBS-refundable items with patient appointment times. This "price and volume" approach was common among the GP Super Clinics. To achieve patient volume, appointment times for GPs were allocated usually at either ten or fifteen minute intervals, with a focus on the medical assessment component, leaving other aspects of patient management to other disciplines. Where possible, appointments for other disciplines were arranged following or prior to those with general practitioners.

The business model was also supported by contractual arrangements between clinicians and the GP Super Clinics. These contracts commonly provided a proportional component of MBS items to the clinicians, with the remaining proportion contributing to the overall income for the GP Super Clinics supporting administrative and other staff to provide the required functional aspects. Forty (75%) of clinicians in the survey indicated that they contracted to provide services by the GP Super Clinics, with the remaining indicating a mix of arrangements.

Bulk-billing for all patients for MBS items was only available in one GP Super Clinic. This GP Super Clinic allocated appointments at ten-minute intervals to achieve the volume required to ensure viability. Most GP Super Clinics indicated that their initial projections under-estimated the proportion of clients who would be bulk-billed, thus necessitating a review of the business model. The majority of clinicians commented positively on the financial viability of the business model for them as individuals. Many indicated that they saw the balance between the model of care and professional satisfaction and the financial viability as critical. Indeed, some indicated they had left previous clinics where income may have been greater but professional satisfaction under the model of care provided made their position untenable.

> I am happy with the business model….. I think my earnings will grow as the clinic grows but it is a balance between money and job satisfaction. Here is a much better environment [than previous] roles and I feel I am doing what I was trained to do…medicine. And the other [disciplines] can do what they need to do. This is a much more efficient way to work than I have had before because of that.
>
> General Practitioner - Interview

GP Super Clinics where most concerns were expressed about the viability of the model identified patient volume as the main contributor to these concerns. In these instances, concerns about the location of the GP Super Clinics, combined with significant negativity from local practices, were suggested as factors impacting on patient volume.

### 6.10 Support for Future Primary Care Workforce

Placements for under-graduate students had been provided at six of the seven GP Super Clinics, and most also had GP registrars. While the focus of this training, at this stage of maturation, had been on medical practitioners, four of the GP Super Clinics had also provided training for nurses or allied health students.

Students, or their supervisors, commented that the experiences of students in this multi-disciplinary environment were positive and educationally beneficial. However, concerns were expressed that while the placements provided experience of multi-disciplinary care, the teaching at their respective universities was still provided in discipline-specific silos.

Even in those GP Super Clinics with universities as partners, there was no evidence of the teaching reflecting multi-disciplinary approaches. Even problem-based learning, which some clinicians perceived provided an ideal opportunity to be undertaken across student disciplines, was conducted in silos.

Patients commented positively about students being involved in care at the GP Super Clinics. None of the patients interviewed indicated any problems with the presence of students in consultations. Indeed, all interviewed commented on the importance of students in this setting in relation to the future health care workforce.

> [Doctor] often has a student with him. He always asks if I mind but I don't. It's important that they are here because they have to learn and the best way to do that is with real patients. Sometimes I have even seen a student first and then [Doctor] comes in and checks them because he is in the room next door.
>
> Patient - Interview

The space provided for teaching and training in most GP Super Clinics was viewed positively by most clinicians. In particular a number of GP Super Clinics had designed spaces to allow for parallel consulting thus supporting placements for multiple students with ease of access by medical clinicians.

### 6.11 Integration with Local Programs and Initiatives

Only a limited number of GP Super Clinics in this evaluation demonstrated proactive approaches to developing partnerships with other health care settings. Where they had occurred they were mostly with aged care settings and focused predominately on the provision of medical care to residents. This operational focus may have been necessary given other priorities for GP Super Clinics in the first 12 months of operation. The impact on the level of integration of care under these approaches was limited, in part because of lack of shared health records between the different facilities. There was even less demonstration of integrated approaches with acute hospitals or in planning for the health needs of local communities.

Non GP medical specialists were also providing services at the GP Super Clinics. These specialists provide services at the GP Super Clinics in a range of specialties, enabling access for patients locally.

# 7 Discussion – GP Super Clinics Program Maturing

The GP Super Clinics Program is part of the Australian Government's health care reforms and, in particular, reflects an increased emphasis on and investment in primary care.[3] Primary care reforms are being implemented in most developed nations due to the impacts of the ageing population and chronic disease.[3,4,6] The objectives of the GP Super Clinics Program reflect these factors with a focus on multi-disciplinary and integrated care to support care for older people and those with chronic disease. They also focus on the need for infrastructure and capacity to support and sustain these models of care.

This evaluation aimed to describe the context, development and short term impact of the program. To achieve these aims a variety of methods were used in relation to the implementation, establishment and operations aspects of the program. These methods involved the review of documentation, and surveys and interviews with stakeholders relevant to each of the three aspects of the GP Super Clinics Program. The results of each of these data collection methods have been reported in previous chapters. This final chapter aims to describe the implications of these results for the GP Super Clinics Program in the context of its objectives, particularly those related to patients and clinicians, and those more broadly related to the primary health care system.

## 7.1 Implementation Aspect - Policy to Program

Optimal outcomes from policy initiatives are more likely to be obtained when there is early and systematic consideration of the practical aspects of implementation into programs and/or services.[25] The Australian Government has a range of guidelines and regulations to support a systematic approach to policy and program implementation.

The results of the desk review process and interviews with Department of Health and Ageing staff demonstrate a high level of compliance with government program implementation and regulation requirements. Indeed, it is the opinion of the evaluation team that the implementation aspect of the GP Super Clinics Program has potential as a model for other program implementation processes.

### 7.1.1 GP Super Clinics Branch Capacity

Ensuring the skills and resources in relevant departments match the requirements is recognised as critical in policy implementation.[25] The funding for the GP Super Clinics Program did not include funds for its implementation. This gap was addressed by the Primary and Ambulatory Care Division of the Department of Health and Ageing by the flexible re-allocation of staff within the Division.

Critical to the implementation of the GP Super Clinics Program was the early identification of skills and resources required for managing capital programs. Some skills were available more broadly in the Department, and partnerships with a focus on contract management, tendering and communication were established. The engagement of a construction advisor may have added value to the establishment aspect if it had occurred concurrently with the contracting for construction of GP Super Clinics in the 2007-2008 tranche. General practice advice was needed

and obtained as part of the development of the *GP Super Clinics National Program Guide 2008* and was included in the ITA processes. These partnerships were invaluable in supporting staff within the GP Super Clinics Branch.

Many of the successes of implementation appear to relate to the commitment, knowledge and now corporate history of staff in the GP Super Clinics Program. Succession planning, is of course, a routine component of management within the Department of Health and Ageing. However, there are significant risks to the Program if staff leave, necessitating the need for rigorous systems to ensure protocols are in place to manage staff turnover.

The learnings of program implementation appeared to have been incorporated into systems within the Branch and, indeed, in other branches within the Department of Health and Ageing. For example, training in managing construction projects is now standard in orientation within the Branch, and amendments to the tool-kit of the Program Funding and Procurement Service have been made, reflecting Program learnings. These are indicative of an evolving program willing to apply lessons as part of an overall approach to improvement.

The development of the *GP Super Clinics National Program Guide 2008* provided an overview of the national arrangements for the Program including the funding arrangements and processes for application.[2] The *GP Super Clinics National Program Guide 2008* was deliberately broad and demonstrated the flexibility within the Program. This was critical for attracting applicants and enabling them to propose models which they believed suited the needs and context of local communities. It was developed through a consultative process and in line with guidelines and requirements for probity.

There was some confusion about content, timing of requirements and expectations for Project Plans after the establishment aspect. This may in part relate to the evolution of the GP Super Clinics Program over time, and the evolution in requirements reflecting learnings as the program progresses. Availability of all documents for desk reviews was not possible, and confusion in terms of the different plans has occurred. Contractual arrangements, including funding and reporting requirements, have developed over time. While there was evidence of this development in documents, it is timely to review all requirements for GP Super Clinics beyond the 2007-2008 tranche.

Two critical factors in GP Super Clinics achieving program objectives are clinical leadership and alignment between the clinical and the business models. These factors are described in detail in Section 7.4. In at least one GP Super Clinic this leadership was not evident. While the ITA process was transparent and sound and included rigorous assessment, it is difficult to capture the qualities related to leadership and alignment between the clinical and business models. If future GP Super Clinics were to be established this suggests the need for ensuring these as factors in the assessment processes.

### 7.1.2 Managing a Long Term Program

Each of the GP Super Clinics has a designated use period of 20 years from the date of commencement of operations. This requires a commitment by the Australian Government to the management of the GP Super Clinics Program for 20 years from the date of the commencement of the provision of services of the last of the GP Super Clinics to be established. Managing this

program will necessitate monitoring how the activities of each of the GP Super Clinics contribute to achieving the GP Super Clinics Program objectives over this long-term period.

Reporting occurs through completion and submission of an annual plan and reporting templates by the GP Super Clinics to the Department of Health and Ageing at two, four and 12 monthly intervals. In their initial stages, these templates have been set up to provide cumulative reports of activity and progress towards achieving the GP Super Clinics Program objectives. This monitoring activity will gain greater scale and complexity as more GP Super Clinics become operational placing significant demands on GP Super Clinics staff and those in the GP Super Clinics Branch.

Reliance on template-based reporting is inefficient and this inefficiency will increase once all GP Super Clinics are operational. In addition, without handling by Department of Health and Ageing staff, the template-based reporting does not have the potential for providing selective or indeed overview reports. Alternative reporting mechanisms, such as those offered by internet data bases for example, offer much more efficient options for reporting for GP Super Clinics Program Directors and Department of Health and Ageing staff more broadly, and importantly, for analysis of data over time. There has been some development of key performance indicators which are currently under consideration for application across the GP Super Clinics Program.

The current funding agreement provides contingencies to ensure GP Super Clinics are providing services as intended under the operational plan. The operational plan is required to detail the proposed operations and details how these will meet the GP Super Clinics Program objectives throughout the Designated Use Period. The funding agreement includes options for repayment of funds or step-in rights of the Commonwealth in circumstances where the GP Super Clinics are not providing services in line with the operational plan.

### 7.1.3 Recommendations - Implementation Aspect

1. The Department of Health and Ageing should consider a review process which aims to consider, critically review and document the evolution of the processes applied in the management of the GP Super Clinics Program. It would be expected that the outputs of this process would clarify requirements for plans, and associated milestones at all stages of the GP Super Clinics Program, would support Departmental staff within the GP Super Clinics Program and other similar programs.
2. The Department of Health and Ageing should explore options for efficient reporting systems, and examine the potential for internet based reporting.

## 7.2 The Establishment Aspect - Managing Funding for Construction Projects

The establishment aspect differed from other government construction programs such as the Building the Education Revolution (BER) Program where land acquisition and, for school projects in the various state and territory education systems, many Planning Authority or Council approvals were not required. Rather, the establishment of the GP Super Clinics is more akin to the processes required in commercial property developments. As a result, the capital component of the GP Super Clinics Program had to deal with the complexities of the land transfer and title, planning and zoning systems of states and territories, and the interweaving of

citizen, business, and government regulatory relationships which occurs in these types of property developments.[35]

The Program provided significant funding for capital development of GP Super Clinics. This required robust contract and risk management. The establishment phase was also undertaken in the period of the Global Financial Crisis (GFC). The GP Super Clinics developments were hence subject to the construction industry and economic challenges of those times. All but two of the 36 GP Super Clinics across 37 sites were completed, with the non-completions due to inability of the funding recipients to raise funds they required above and beyond those provided by the Australian Government. One of these is expected to be completed when negotiations regarding additional funding are finalised.

A number of the sites were located on land owned by an authority, for example a state-based health service, which was provided under a variety of lease arrangements to enable the building of the GP Super Clinics. In a number of instances these were in locations which may not have been the preferred site of the GP Super Clinic Directors or may not have been optimally accessible for patients. However, the provision of land under these arrangements represented a significant investment at those sites in the GP Super Clinics and, as such provided opportunities which could not be ignored. However, in at least one instance, because of less than ideal access for patients, this may present problems in the longer term.

### 7.2.1 Evolution in Establishment Aspect

Managing programs with significant capital components is complex. It requires skills outside those normally available in government health departments. The GP Super Clinics Program has demonstrated evolution in the skills and understanding of the requirements for managing funding for construction programs. This expertise has contributed to the development of overall management and in particular to the development and evolution of the contractual requirements of the funding recipients as the GP Super Clinics Program matured.

### 7.2.2 Managing Delays in the Construction Processes

Delays in the various phases of development occurred in the GP Super Clinics Program. Many of these delays appeared to relate to inaccuracies in estimates, by the Directors and associates, of times associated with the processes required for the design, documentation and approvals for construction of the GP Super Clinics. Once the GP Super Clinics were committed to construction, the rate of completion almost universally aligned to contract requirements.

Given many of the GP Super Clinic Directors were medically trained it is hardly surprising that estimates of time for the other phases of development were inaccurate. However, particularly post-2010, most Directors contracted independent project managers who had a greater understanding of these processes and timeframe implications. These findings suggest the need, in this or similar programs, for funding recipients to include for the appointment of these management resources at project development stages much earlier than they might assume them to be required.

### Land Acquisitions

Most GP Super Clinics developments that have included one form of land acquisition or another as an essential component of their delivery, have not progressed to the original program or Funding Agreement milestones. As with commercial property developments, it is common for construction projects that include land acquisition, to experience subdivision or consolidation of existing parcels of land commonly taking longer than the transfer of title in a single block of land because of the multiple processes involved.

Funding recipients should have an extensive understanding of these multiple processes and the resultant effects on final land acquisition. This was not evident and therefore is a potential risk not only to the funding recipients but also to the Department of Health and Ageing. The Funding Agreement approach of requiring a measurement of progress on land acquisition against only one milestone date – the date on which the funding recipient is to notify full and final tenure over the land - does not reflect a sufficient number of interim steps in the process for the Department of Health and Ageing to be able to monitor that progress effectively until too late.

### Development Approval and Re-zoning

Development approval and re-zoning requirements are always unpredictable in any form of construction or property development. No-one is in a position to correctly anticipate planning approval times regardless of relationships with Council or Council members. Ultimately, the planning staff in the Council office, and the public in the case of public notification and consultation, will finally determine these outcomes.

In the GP Super Clinics Program 2007-2008, virtually all initial estimations of the timelines for DA approvals were inaccurate. In the initial design and development application submissions, funding recipients and/or their architects did not correctly anticipate Councils' requirements for these land uses. These errors in estimation have always led to delays, most of which were incorrectly blamed on the Councils.

The GP Super Clinics are generally classified in urban planning Law and Regulation around the country as a "Medical Centre" or "Health Care Building". Consequently, the GP Super Clinics have tended to be encumbered with significantly greater requirements for parking than other, similar land uses (e.g. professional offices). The relatively tight requirements of the GP Super Clinics within these two definitions (as opposed, for example, to "Shop" or "Office") has, in several cases, required some level of re-zoning because the existing zoning did not provide for this land use. In contrast, GP Super Clinics that have been or are being developed on "campus" land (whether university or hospital campus) have generally been delivered with fewer DA delays because "third party" Council approvals are not required.

Re-zoning (or Material Change of Use in some states) has always required additional, lengthier approval processes through Councils and has been a trigger for demands from Councils and Utilities for "extra-over" infrastructure works.

### Funding

There is no evidence that any of the GP Super Clinics have been delayed by funding processes within the Department of Health and Ageing. The majority of funding delays have, in fact, been

budget over-run delays. The budget over-run delays have been, in the main, the result of non-existent, late or ineffective application of qualified design management or cost planning resources to the designs.

In a few notable cases, the legal securing of funding from third parties has been unreliable. The consequences of a shortfall of funds at or near the end of the construction phase of a project are always expensive and generally highly problematic for the progress of the project. This was evidenced by the circumstances behind the two GP Super Clinics which were not completed at the time of this evaluation due to their inability to secure additional funding .

**Appointment of Contractors**

Delays in obtaining Building Approvals (or Construction Certificates) to allow building commencement have generally been due to the "carry-over" effects of DA approval conditions into BAs. There has only been one instance of delays arising through poor documentation and/or tardiness on the part of a funding recipient. There has been only one instance of delays arising because the funding recipient chose a non-competitive construction delivery approach.

**Construction Delays**

There have been few, if any, major delays to practical completion during the construction phase, that have not been related to funding shortfalls. A significant number of GP Super Clinics have been delivered on program.

There has, however, been significant evidence of funding recipients not incorporating more "time is of the essence" provisions in their building contracts. Further, there has been significant evidence of funding recipients not using the preferred AS 2124 form of contract. In both these instances variation-driven delays and cost increases have resulted.

There have been a number of instances of funding recipients requiring design changes after construction has commenced or is well advanced. Design changes after commencement of construction always cost more than usual (because they are procured in a non-competitive setting) and nearly always delay the project. These design changes have been linked, in some instances, to problems with sourcing additional capital (by loan or other investment).

In summary, there are lessons and recommendations which are applicable more broadly for managing grants programs with capital funds for property development. Of all 36 GP Super Clinics across the 37 sites, which were commenced in the establishment aspect of the program only one is not continuing. This was due to the Funding Recipient's inability to secure funding required in addition to the capital component provided by the Australian Government.

This failure to complete rate (2.7%) of the total number of GP Super Clinics committed or 5.6% of completions as at the date of the surveys needs to be viewed in the context of construction in Australia at this time. Given the financial conditions during the past three years this rate is very low. The Construction Sentiment Monitor published by Davis Langdon in August 2011 records: "*Worries about the GFC and a shortage of work have eased somewhat, while the relatively new problem in sourcing project finance persists.*[36] Their projection of future risks included: *"Looking ahead, industry respondents do not expect financing difficulties to subside anytime soon. The cost, conditions and availability of debt are an ongoing risk to project viability."*[36] The availability

of finance was the largest single risk to the property development and construction industries in Davis Langdon surveys (17%).[36]

### 7.2.3 Recommendations – Establishment Aspect

The recommendations outlined in this section reflect the findings of the evaluation relative to GP Super Clinics established in the 2007-2008 tranche and the documents associated with this stage. Some of these recommendations need to be considered in the context that the GP Super Clinics Program has evolved and some may indeed have already been implemented. Importantly, in building on the lessons learned, these recommendations may have relevance to the development and implementation of other programs by the Australian Government, particularly, those which have substantial capital components.

3. Funding recipients should be required, in the application and post-application stages, to detail their understanding of the land acquisition process and the deliverables associated with each of these stages.
4. Funding applications that involve land subdivision or consolidation should be subject to extra scrutiny and review to ensure the timelines are realistic. In this regard, Risk Assessments and Risk Management Plans submitted by funding recipients should not be accepted until they accurately and properly recognise and plan for these increased risks.
5. The Department of Health and Ageing should move to continue and expand the process now in place and evident from the desk review of the later funding agreements to increase the number of milestones, milestone dates and the details regarding what these milestones are to produce, as outcomes for the land acquisition phase. The Department of Health and Ageing will then be in a better position to monitor the delivery of these more regular, detailed outcomes, with a view to demanding corrective action from the funding recipients if slippages occur.
6. Funding applicants should be required to submit, with their applications, parking studies that are certified by traffic engineers to be compliant with the relevant Council's published Parking Guidelines and the relevant Australian Standards.
7. Funding applicants should be required to submit, with their applications, a statement from the architect or urban planning consultant (if engaged at that stage) setting out in summary form what the consultant believes to be the relevant planning rules that the proposed development has to meet. In the Australian Capital Territory this is a mandatory requirement for a DA submission and is called a "Statement Against Relevant Criteria".
8. Funding applicants should be required to submit, with their applications, a statement from the architect or urban planning consultant (if engaged at that stage) setting out in detail what they believe to be the processes involved in Council, other agency and utility approvals. For preference, this should take the form of a Critical Path Gant Chart and be coordinated, with respect of Critical Milestones, with both the Funding Agreement Schedule of Milestones and the primary risks in the Risk Assessment and Risk Management Plan. These Gant Charts should contain significant "float" for the potential delay effects.
9. All Milestone Schedules should be expanded in both number and detail to allow closer monitoring of progress along the lines set out under "Land acquisition" in Section 7.2.2.
10. Timeline programs that describe requirements for re-zoning of land (variously identified as

"Material Changes of Use", "Variations to Local Environmental Plans" etc.) should be closely inspected and interrogated for compliance with statutory, regulatory and likely procedures and outcomes. In virtually all jurisdictions, re-zoning is a process that rarely requires less than six months to complete and can extend to two years.

11. Proposals that require re-zoning of land should also be required to engage the services of planning consultants at the earliest stages of the approval process. A template for monitoring and reporting of the steps involved in any re-zoning process should also be developed and made the basis for monitoring by both the funding recipients and the Department.
12. In the cases of both land acquisition and re-zoning, a more pro-active approach by the Department in providing the reporting templates to the funding recipients at the outset will greatly assist in ensuring that adequate time allowances are made in project programs, early warning of variances from the process and program is given, and appropriate reactions and corrections to slippages are put in place.
13. Funding recipients should be required to provide from their banks or financial Institutions, letters of confirmation of sufficient funding to commence and complete the projects.
14. Funding recipients should also be required to establish stand-alone bank accounts for the receipt and expenditure of all funding for the projects and should require submission of transaction records, on bank letterhead, every month.
15. Non-competitive contracting arrangements should be discouraged unless the funding recipient can demonstrate substantial benefits from a non-competitive process.
16. Bills of Quantities should be required for all construction projects valued in excess of $3 million.
17. Form AS 2124 should be mandated for use in all construction contracts.
18. The Department should refuse approval to proceed with the engagement of contractors until acceptable "time is of the essence" clauses related to variations, delays and extensions of time are included in the construction contract;
19. The funding recipients should only be permitted to vary designs after award of the construction contracts, when essential to the compliance of the buildings with applicable Codes and Standards. All other design changes to the size, amenity or function of the buildings should only be permitted after submission and prior approval of a written Impact Assessment to the Department by the funding recipient

### 7.2.4 Value for Money

The value for money assessment in the capital component of the GP Super Clinics Program determined that six of the GP Super Clinics were outside the criteria for value for money. If the extra-ordinary circumstances of three of the GP Super Clinics had been factored into the value for money assessments, it is likely that they would also have otherwise met the value for money criteria leaving three remaining sites as out of range of acceptable value for money.

There has been considerable debate in the property development industry as to the appropriate criteria for the measurement of value for money outcomes of construction projects. In a recent

example, the BER Implementation Taskforce used a methodology that defined value for money "as a product of three elements that the Taskforce and its Industry Advisory Panel saw as essential":

- Quality
- Time
- Cost.[37]

In assessing cost, this Taskforce used a "regionally adjusted" (for remoteness from the major population and industry centres) $ cost per $m^2$ of gross floor area (GFA), noting GFA is a term defined by the Property Council of Australia.

This evaluation does not, however rate either quality or time in the value for money measurement; the former because such an assessment would have required extensive and detailed inspection of those 18 GP Super Clinics projects completed at the time of survey. It would also have created insurmountable difficulties in comparing value for money on completed projects with those still in construction and those on which construction had not yet started.

Time was not included as a measure of value for money because, unlike the BER program where the projects were on land always already owned by the schools and with little or no requirement (except in relation to the private and independent school projects) for Council approvals, the GP Super Clinics have been subject to a multitude of varied, additional development stages that would again have created insurmountable difficulties in comparing, for example, a project that required land acquisition and full Council approvals with one on a university campus that might have required neither.

The one other element of a value for money assessment that may well be valid to both the BER and GP Super Clinics Programs is whether or not the buildings delivered under the program meet a need, or meet that need in a sensible way. This assessment is not canvassed in either the BER Taskforce Report or in this evaluation. By way of illustration in the GP Super Clinics context, one could validly ask, subjectively, whether or not the addition of a $700m^2$ second storey to an existing GP Clinic for a cost of over $4 million represented value for money in comparison with, say, an alternative development on a "Greenfield" site. The relatively simple evaluation of this project on a $ cost per $m^2$ GFA suggests that it does, by a margin of only $67 per $m^2$, but the more subjective evaluation of meeting need may conclude otherwise.

The measurement and assessment of value for money aligned with construction industry approaches. The measurement was reliant on data provided by funding recipients in the survey responses in relation to cost elements, including breakdowns to be used in the value for money assessment. These elements were not readily available in most funding agreements; hence there was reliance on self-reported survey data.

The value for money assessments did not include evaluations of two significant components of the development costs of these projects:

- Professional fees

- Land Purchase cost.

Professional fees were not assessed as part of value for money because a number of the projects, to varying degrees, were carried out under "Design and Construct" contracts with many of these professional fees, therefore, incorporated in the overall construction cost per $m^2$. In addition the range of professional services required by particular projects and, therefore, the cost of the professional fees, varied considerably across projects. As an example, complex property acquisitions requiring re-zoning will inevitably attract more fees (e.g. for legal advisors, surveyors, planning consultants) than simple developments on "Greenfield" sites zoned for the required land use. Given these variations any uniform or standardised assessment tool would have affected the accuracy of assessments by either under- or over-representing the value for money.

Land acquisition value can only be properly assessed on an individual, site-by-site basis, using registered land valuers and industry accepted valuation techniques. Such assessment was beyond the terms of this evaluation.

It was not, nor are tools available for, a broader assessment in the context of primary care. In the longer term its assessment in terms of the contribution to evidence-based quality of care, patient access and experience, and clinician experience will be a more ultimate assessment of value for money.

#### 7.2.5 Recommendations – Value for Money

20. Funding applicants should be required to provide the detailed elemental cost break-ups of their projects as was required by the Funding Recipient Surveys for checking against the templates prepared as part of this evaluation.
21. The Department should commission a review of existing templates and the preparation of specific value for money criteria for future use in assessment of Funding Applications for GP Super Clinics.
22. The Department needs to consider options for ensuring that non-construction cost components of the developments, such as land and/or building purchase costs and consultant's fees are not inflated by Funding Applicants
23. The Department should consider longer-term approaches for assessing value for money in the context of primary care.

### 7.3 Progress towards Achieving the GP Super Clinics Program Objectives

The results of this evaluation have demonstrated that there has been considerable progress towards achieving the GP Super Clinics Program objectives. Where progress was less than optimal, opportunities for support for service development will need to be considered.

#### 7.3.1 Multi-disciplinary Care

Multi-disciplinary care involves a range of professionals and commonly includes medical, nursing and allied health professionals. Multi-disciplinary care has been demonstrated to improve outcomes especially for patients with chronic illnesses.[16,38] Key to the primary care

reform under the GP Super Clinics Program was improved care and outcomes for people with or at risk of a chronic illness, and for older people.

High quality chronic disease management requires "a longitudinal and preventive orientation manifested by well-designed, planned interactions between a practice team and a patient in which the important clinical and behavioral work of modern chronic illness care is performed predictably".[39] Ideally, this requires an integrated and coordinated approach by a multi-disciplinary care team with regard to assessment, treatment, support for self-management and follow-up.[39]

Evidence for multi-disciplinary care is derived from research on specific models and from the roles of particular disciplines. There is evidence that multi-disciplinary teams can improve outcomes in a range of patient groups.[16,38,40] In both acute and primary care settings multi-disciplinary care is associated with improved clinical outcomes and other indicators such as reduced hospital admissions.[41] Indeed, there is increasing evidence that the design of the care team and the contribution of disciplines are the primary determinants of quality of care for people with chronic illnesses.[39] Importantly, evidence exists that these outcomes accrue to disadvantaged groups within communities.[23]

Primary care nurses undertake a multitude of tasks in general practice, only some of which are funded under some form of fee-for-service model.[42] The funding arrangements changed in 2012 to provide incentives for practices to enable employment of nurses to undertake broader roles than those funded under the fee-for-service model. Nurses can provide the same quality of care and achieve equivalent health outcomes for patients with certain conditions as doctors, and given the right organisational climate can contribute to improving the quality of care in General Practice.[42,43] Similarly, allied health staff in primary care have demonstrated improvements in quality of life and reduced hospital admissions for patients with chronic illnesses.[44]

The elements required for effective and integrated models for multi-disciplinary care include flexibility and cooperative team-work with a clearly identified coordinator and supported by effective communication processes. These models are enhanced through the use of evidence-based polices, guidelines and protocols pertinent to the multi-disciplinary team.[45]

The provision of multi-disciplinary care alone within a single practice will not ensure that care is integrated for patients across the discipline spectrum. The challenges facing most modern health care systems require integration between the elements of health care in order to meet patients' needs, particularly those with chronic illness.[17] Integrated care is defined as patient care that is "coordinated across professionals, facilities, and support systems; continuous over time and between visits; tailored to the patients' needs and preferences; and based on shared responsibility between patient and caregivers for optimizing health."[17] Promoting the concept of integrated care assumes that patient experiences and outcomes are better under models where care is integrated among systems, facilities and clinicians.[17]

Integrated care goes beyond the sharing of information, such as provided through a shared electronic health record.[46] It needs to be complemented by formal and informal relationships among disciplines to support communication, and by shared care planning.[47] Mechanisms which have traditionally been applied to support integrated care, but were less than optimal,

have been sharing of written patient records, informal communication within practices, referral letters and visit summaries with providers external to the practice.[47]

The GP Super Clinics are implementing multi-disciplinary care especially for patients with chronic illnesses. That is, patients are receiving aspects of their care from multiple disciplines. The high level of positive patient experience in relation to the care provided at the GP Super Clinics is an indication of contribution to patient need. In most but not all instances, this care was integrated within the GP Super Clinic setting. The co-location of multiple disciplines under one roof and the shared electronic health record were perceived as major contributors to integration.

The extent to which the models of multi-disciplinary care were evidence-based was not as obvious. Co-location and a shared health record alone may facilitate, but do not constitute, multi-disciplinary care. Indeed, there is a risk that in the absence of a greater focus on applying evidence-based guidelines which reflect the multi-disciplinary nature of care, health outcomes which are expected to accrue from this type of model of care may be less than optimally achieved. An over-reliance on corridor conversations and shared electronic health records has the potential to neglect evidence and quality, and thus limit patient outcomes.

There are a number of unanswered challenges in relation to the application of multi-disciplinary models in GP Super Clinics. Guidelines which are being used in GP Super Clinics, have commonly been adapted from those developed by the RACGP or other discipline specific organisations. The GP Super Clinics are a relatively new structural approach to provision of care and hence offer a range of opportunities for research questions and testing interventions specific to this type of setting. As they are sites of excellence in new models of primary care, GP Super Clinics have potential to work in partnership with universities and other research bodies to answer some of these questions.

**Clinical Governance**

Under the GP Super Clinics Program objectives, models of clinical governance and shared care protocols are expected. Clinical governance is defined as a systematic and integrated approach to assurance and review of clinical responsibility and accountability that improves quality and safety resulting in optimal patient outcomes.[48] As in other health settings, clinical governance approaches in primary care provide some fragmented evidence of impact on quality.[49]

Involvement of primary health care providers in clinical governance at the local level is recommended as having most potential, particularly if supported by regional networks and structural changes nationally to allow for funding for time for clinical governance, and information systems to access clinical data.[49] A key concept in the GP Super Clinics Program objectives was that clinical governance would reflect the multi-disciplinary nature of care.

There are a range of approaches for achieving effective clinical governance, including: continuous improvement, quality assurance, audits, using clinical indicators, promotion of evidence-based practice, participation in accreditation processes, risk management, and a suite of other activities.[50] Reporting of clinical performance data to clinical teams, including those in primary care, as part of clinical governance initiatives, has been shown to result in significantly improved clinical outcomes.[51 52]

Some of these approaches have been applied to some extent in all GP Super Clinics. However, there was very limited evidence of formal, systematic approaches to and multi-disciplinary involvement in clinical governance approaches. Implementing clinical governance in multi-disciplinary settings such as GP Super Clinics was reported by clinicians as being an area where they had limited previous experience. As such it is an area that requires close attention in the short term, and regular monitoring in the long term.

### 7.3.2 Responsiveness to Local Community Needs

Community participation is regarded as one of the key pillars of primary health care.[53] This is in part due to evidence of impact on the health of the communities and in part to notions of democracy and a civil society. In line with the GP Super Clinics Program objectives, the World Health Organisation (WHO) also emphasises the need for the primary health care sector to be responsive to local community needs through community participation and engagement.[10] Similarly, a consensus process undertaken in Canada to determine attributes of primary care, identified a number of community-oriented dimensions including community participation, and responsiveness to the needs of the population.[54]

There is a range of evidence to support the impact of community participation in achieving clinical and population health outcomes.[53] Despite this, community participation is considered one of the weakest strands in primary health care, requiring a strong policy and practice emphasis.[55] Importantly, evidence exists for the impact of participation on disadvantaged groups nationally and internationally. For example, chronic disease programs for Aboriginal Australians were most successful with a high level of Aboriginal community engagement and effective communication at all levels, with flexibility to meet local needs.[56] Strategies for enhancing capacity in community engagement for primary health professionals at local and national levels are strongly recommended.[10,55]

All of the GP Super Clinics had undertaken some form of needs assessment prior to commencing operations, as part of the application process and in contributing to the operational plan. Approaches included examining local population health data and health service activity, as well as general and specific consultation strategies.

Few of the GP Super Clinics have developed or implemented ongoing processes for community engagement. Given the stage of development, this is hardly surprising. However, opportunities for more strategic approaches to community engagement and community involvement in organisational governance are required if the GP Super Clinics are to meet local needs.

GP Super Clinic Directors appeared uncertain as to the approaches for community engagement, which could be applied in an ongoing and strategic manner. As Medicare Locals develop, there is potential for collaborative approaches to community engagement to support GP Super Clinics to meet local needs. Similarly, it would be expected that partnerships with local health services and potential for shared planning could be achieved. These approaches would be dependent on relationships between the GP Super Clinic Directors and these other health organisations.

**Aboriginal and Torres Strait Islanders**

There were some outstanding examples of engagement with the Aboriginal community. However, these were in the minority. Where these outstanding examples of engagement had occurred, they were simple, consultative strategies which were ongoing. The importance placed on engagement reflected a commitment of the Directors to addressing Aboriginal health in the local areas. While the GP Super Clinics Program emphasises the importance of engagement with the Aboriginal community, greater emphasis is needed on this important area at local levels. There are also opportunities for sharing strategies among GP Super Clinics which have not yet been realised.

### 7.3.3 Accessible, Culturally Appropriate and Affordable care

There appears to be a net increase in access to primary care in the localities of the GP Super Clinics. This is evidenced from the numbers of additional GPs providing services at the GP Super Clinics who have moved to the area from another location. Further, there appears to be a net increase in other disciplines providing services to the area. These data are further supported by patient comments regarding ease of access for appointments compared with long waiting times at other clinics in the area.

All GP Super Clinics provided bulk-billing in some form, mostly to groups such as children less than 16 years and those on health care cards, with only one providing bulk-billing to all patients. The financial viability under a total bulk-billing model was questioned, with the structure of, and amount of remuneration under the current MBS system, cited as the most significant barrier.

The fact that the majority of patients surveyed indicated they were there to see their usual doctors contradicts criticisms about the GP Super Clinics suggesting that patients would not have regular doctors but would have to have appointments with any doctor available on the day. These results, which are reinforced by comments from interviews of patients and clinicians, indicate that most patients have “usual” doctors unless there is a need for an urgent appointment.

Most of the GP Super Clinics provided extended or after-hours services in some form. To date, none of the GP Super Clinics reported being at capacity in terms of patient numbers. Given that most of them had been operating for less than twelve months at the time of evaluation, this is hardly surprising. All of the GP Super Clinics were expecting to increase patient numbers over the next three years.

### 7.3.4 Preventative Health Care

The causes of chronic disease are largely attributable to risk factors such as smoking, misuse of alcohol, nutrition and physical activity.[57] There is a plethora of evidence indicating the impact of GPs on these risk factors at patient and population levels. Despite a range of initiatives in general practice including those related to MBS items for preventative care, uptake is less than optimal.[58],[32]

The role of GP Super Clinics in relation to preventative health care has been mainly in relation to secondary prevention. In particular, it has been focused on reducing risk factors and improving self-management in patients with chronic illness.

The results from this evaluation suggest a number of issues in relation to preventative care in the GP Super Clinics. The first is potentially a lack of understanding of preventative care in the context of the whole patient population, particularly regarding primary prevention for patients without disease. Second, results suggest a lack of focus on preventative care in general in the GP Super Clinics to date. This may be understandable in the context of their maturity, with other priorities, particularly those related to chronic disease management, considered more important. Third, the lack of data about patient populations' risk factors, limits options for a focus on primary prevention. If these data were used they could potentially drive priorities and strategies for primary prevention. These data are potentially available in the GP Super Clinics' electronic health record systems, but their use in terms of the patient population and risk factors has not been realised. Last, financial reasons related to MBS items for preventative health care, were commonly quoted as barriers to preventative care.

Regardless of the reasons, these results suggest missed opportunities for preventative care, particularly for primary prevention. Hence, the potential for reducing the future burden of disease in the patient populations and in the communities served is not currently being achieved.

### 7.3.5 Effective Use of Information Technology

Electronic health records shared among disciplines, have the potential for achieving a range of practice, system and patient efficiencies.[59] Use of electronic health records enables sharing of data across the continuum of care, potentially across healthcare delivery organisations, across time and across geographical areas.[60] The electronic health record usually contains a range of patient information, such as existing health conditions, physician visits, hospitalisations, test results and prescribed drugs.[60]

All GP Super Clinics were using some type of electronic health record, supported by appropriate levels of compliance with privacy requirements. The electronic health records were strongly supported by the majority of clinicians as facilitating models of multi-disciplinary care. More importantly, their use was supported by patients who commonly recognised the value in having their records accessible by a range of clinicians within the GP Super Clinics.

Evidence of the use of data from the electronic health records to contribute to health service planning, review and quality improvement was limited. There is potential for GP Super Clinics aggregate data to be used for these purposes and with maturation this may develop as an important opportunity.

The potential for sharing electronic health records with external providers has not yet been realised. However, plans for this eventuality are underway in two of the GP Super Clinics. The lessons in sharing of the electronic health record with externals have potential to be shared across all GP Super Clinics to support improved integration of care.

### 7.3.6 Impact on Primary Care Workforce

There are significant challenges for the primary health workforce in its supply, its distribution among metropolitan, regional, rural and remotes areas, and its changing roles.[61] Workforce models implemented in primary care commonly involve a mix of substitution, delegation, enhancement, innovation and supplementation.[16,62] Most new models have focused on

increased access to a broader range of primary health care providers, such as practice nurses and allied health staff.[16] These models reflect the changing models of care within the primary health system.

Emphasis in workforce models where there is a broader range of health professionals has been on defining these roles individually, rather than on the way staff work as part of a team.[16] Given the evidence that team-based approaches to areas such as chronic disease management have demonstrated better clinical outcomes and improved quality in general practice, a key element for workforce development should be teamwork.[42,51]

One of the ultimate tests of the GP Super Clinics Program will be seen in terms of recruitment and retention of clinicians to work under this model of care. The question is - will GPs and allied health staff want to work in multi-disciplinary primary care environments such as those offered by GP Super Clinics?

In these very early days it appears that the answer may be yes. The results from this evaluation indicate clinicians of all disciplines and students have a high level of professional satisfaction working under this model. This is not to be underestimated in terms of a retention factor. Opportunities for teaching, training and research were also cited as factors impacting on recruitment and retention. Indeed, examples have been provided where GP Super Clinic Directors are being contacted by clinicians who want to work under this model. In combination with positive patient experiences of these models of care, and students being trained in these GP Super Clinics, these may be more telling long-term factors in driving reforms in primary care than a raft of other initiatives.

If the answer to the question is yes, this also has significant implications for the rhetoric of some of the professional organisations representing medical and other disciplines regarding GP Super Clinics. The representation of GPs is challenging with diversity in views, values and philosophies.[63] This diversity often relates to economics, ideology and the role of government in general practice.[63] Hence it would not be expected that there was universal agreement with or support for the GP Super Clinics Program. However, if the answer to the question regarding willingness to work in GP Super Clinics is yes, and it aligns with patients views about their experiences with health care suggested by this evaluation, then maybe it is time to review responses to new models of health care delivery, in the context of patient and clinician experiences.

### 7.3.7 Quality in Primary Health Care

Quality in primary care is complex, and due to the nature of multi-disciplinary care and the many conditions treated, it is by its nature multi-dimensional.[34] Health outcomes, both in terms of positive health and absence of disease, are the ultimate measures of the quality of primary care, but also require appropriate structures and processes for their achievement.[34] The dimensions of quality have been the subject of significant debate. Recent work in the United Kingdom has attempted to articulate the core dimensions of quality as clinical effectiveness; safety, and patient experience.[34,64]

Patient experience has not always been a key dimension of clinical quality, with the focus on effectiveness and safety. In general practice and in primary care, patient-centred care is a core value.[65] Despite this, there is evidence of less than optimal levels of patient experience and

patient engagement.[34] It could therefore be assumed that assessment of patient experience is an important element of any quality approaches in primary care.

Traditionally, many of the health system initiatives to improve quality have been implemented in the acute health care sector.[66] While a number of approaches to ensuring high quality health care in primary care have been reported, evidence for their impact is limited in part because of recency of focus in this setting.[66] Where evidence does exist, it suggests that larger practices have higher levels of performance than single practices.[4] Clinical audits and significant event audits are commonly reported within general practices, but often in the absence of a systematic approach to quality.[67]

Critical to quality improvement approaches in primary care, and important to accountability for funds provided by government, are a set of robust indicators.[59] Despite the evolution of primary care in developed nations, there is limited consensus on the indicators which are used to measure the impact and performance of primary health care systems.[66] Where evidence of a focus on quality improvements does exist, it is in areas where measurement is easiest, such as in prescribing practices.[49]

Cross professional clinical leadership is considered a prerequisite for ensuring quality across the whole primary care team.[66,67] Access by all members of the primary care team to robust data on agreed indicators is needed to determine areas for quality.[66,68] The focus on team-work as part of the overall approach to quality is strongly recommended, given the inherently team-based nature of general practice.[68] Approaches should engage and empower staff in measuring and improving quality, accountability for improvement and continual, rather than periodic approaches to quality.[68]

While most health care is provided in primary care there is evidence that the quality is variable suggesting considerable scope for improvement.[34] For example, an Australian study reported that only about 50% of patients with diabetes received care reflecting evidence-based guidelines.[69] Evidence also suggests that two errors occur for every 1000 Medicare items in general practice.[70]

Many of the approaches to improving quality in primary care appear to be project-based, such as collaboratives and development of disease-specific protocols and guidelines. However, there is a view that these project approaches are not embedded into primary care as part of its inherent culture.[34] This is, in part due to lack of robust data and measurement tools, which can contribute to understanding variations in quality outcomes.[34] In Australia it is further attributed to lack of agreement on the outcomes for primary care and mechanisms for their collection.

There is evidence that attempts at achieving quality outcomes are occurring in GP Super Clinics but are focused on projects with little attention, understandably at this stage of their maturation, to embedding the systems in to everyday practice. There were examples of participation in collaboratives and adoption or some adaptation of evidence-based guidelines. The process of collaboratives has the potential, on a project basis, to support mechanisms for quality improvement. However, in the absence of their application in a more strategic framework their ongoing use and effectiveness are more limited.

In meeting the future health needs of the population, primary health care needs a strong research and knowledge base and research culture.[71] To date, there has been an over-reliance

on research undertaken in hospital or specialty settings which do not reflect the models of care, patient populations or contexts of primary care.[71] Where guidelines have been used they were mostly related to adaptation of evidence-based guidelines for particular conditions such as those of the RACGP. These are not necessarily multi-disciplinary in nature, and do not necessarily reflect evidence from multi-disciplinary settings. Given the close linkages with universities at some GP Super Clinics, there are opportunities for research on interventions in these unique settings, with the ability to shape the nature and quality of primary health care. The uniqueness of the multi-disciplinary nature suggests the potential for linkages in research, with a focus on intervention effectiveness, across all GP Super Clinics. To be of maximum benefit, such research should involve collaboration between researchers and clinicians from GP Super Clinics. Rather than just being points for data collection, the GP Super Clinics should have an active and strong role in determining research questions, measures and interventions.

### 7.3.8 Efficient and Sustainable Business Models

Most but not all of the GP Super Clinics indicated that they were on track to achieving financial viability. The models were commonly based on a model of price and volume – the combination of remuneration of MBS items (both bulk-billing and gap payments) and patient volume – achieved through patient numbers and appointment times. Where viability was most difficult was in GP Super Clinics where patient volume was problematic. This was not a function of appointment times but rather a function of insufficient patient numbers relative to the number of available appointments. Where this occurred, geographical access to the GP Super Clinic within the locality was expressed as a significant barrier.

The financial models of most GP Super Clinics had underestimated the proportion of patients eligible for bulk-billing. Given availability of these data on both demographic and bulk-billing rates per area, this was surprising. In these instances the financial models are, as they should be, under constant review.

### 7.3.9 Support for the Future Primary Care Workforce

Provision of and funding for clinical placements for medical and nursing staff are critical to developing workforce capacity in primary health care.[61] Approaches should also include enhancing the focus on primary care in all levels of training for all health professionals to reflect the model of care being provided.[61]

The GP Super Clinics provide a unique setting for education and training of the future primary care workforce. Their multi-disciplinary nature has the potential for and presently provides placement opportunities for medical, nursing and allied health staff. In recognition of this universities are partners in three of the seven GP Super Clinics with specific space allocated within the buildings for these purposes.

Most of the placements provided were for medical under-graduate or post-graduate students. Plans were in place in most GP Super Clinics to increase placement opportunities for disciplines other than medicine. The space in most GP Super Clinics facilitated a range of teaching models enabling access for students from many disciplines. Importantly, patients recognised the value of students' roles at the GP Super Clinics.

### 7.3.10 Integration with Local Programs and Initiatives

Partnership approaches across all health settings have been growing in most developed nations, based on the assumption that integration improves outcomes of care.[72] Primary care is the most common provider of health services in Australia but is one part of a complex array of services which meet the population needs.[9,16] In Canada it has been demonstrated that increased access to primary care alone does not result in better performance.[6] Rather, the organisational model of primary care and its integration into the broader health system are key factors in improved performance.[6]

There are significant challenges in developing partnerships between primary care and other health settings such as aged care facilities and acute hospitals.[72,73] Given the complexity of patients' needs in aged care, partnerships with multi-disciplinary teams such as those provided by GP Super Clinics have the potential, strategically and operationally, to meet the needs of older people. Similarly, there would be advantages for partnerships with acute hospitals and community health centres.

Evidence for the development of partnerships with other health services was limited. Where they had been established they related mainly to specific clinical services such as providing medical care in aged facilities. The expectations of the GP Super Clinics Program far exceed this, with potential for partnerships in planning and delivery of health services. With maturation, it would be expected a more strategic approach to the provision of integrated health care to meet local health needs could be developed. Under concurrently occurring national reforms, new structures such as Medicare Locals (independent primary health care organisations) and local state health services, have joint responsibilities in the partnership with GP Super Clinics.

### 7.3.11 Recommendations – GP Super Clinics Program Objectives

These recommendations relate specifically to the operation of services within the current GP Super Clinics in the context of the Program objectives.

24. Support for service development for GP Super Clinics should focus on:
    a. Preventative care
    b. Evidence-based multi-disciplinary care
    c. Community engagement
    d. Partnerships with other health services.
25. Partnerships between universities and all GP Super Clinics, potentially in the form of research networks, should be fostered to create strategic research opportunities, which address important questions about multi-disciplinary models of care and interventions which reflect patient needs.
26. The Department of Health and Ageing should establish a clinical governance framework for local adaptation and application in all GP Super Clinics, and link it's associated reporting into the regular reporting requirements.

## 7.4 Operational Aspect Learnings for the GP Super Clinics Program

There are a number of learnings which are specific to the Program as a whole, and not directly related to any of the ten GP Super Clinics Program objectives.

### 7.4.1 Program Maturation

The seven GP Super Clinics participating in this aspect of the evaluation had mostly been operating for less than twelve months. Most of these GP Super Clinics had clear, if not always documented priorities. In their first twelve months of operation these priorities understandably related to recruitment, systems and policies and providing services to achieve the GP Super Clinics Program objectives. This priority setting makes organisational and business sense. Most businesses, regardless of their nature, will set priorities for achievement, especially in their infancy. Indeed, evidence in health care indicates that successful organisations give themselves permission to prioritise.[27]

In these GP Super Clinics, now that the first twelve months have been mostly successfully navigated, it is timely to determine strategic priorities for the next few years. There are some obvious priorities for the GP Super Clinics, including quality, engagement with specific groups, and preventative health care. Each GP Super Clinic may also identify additional, locally specific priorities.

Service development is the responsibility of GP Super Clinics as part of their strategic planning processes to achieve the GP Super Clinics Program objectives; this also make smart business sense. Undertaking an evidence-based approach to this will require leadership and engagement of clinicians and importantly, patients, local community and other health care providers in the area.[27] The role of the Department of Health and Ageing may only be in requiring this to occur and where relevant providing policy guidance.

### 7.4.2 Leadership and Culture

Leadership and organisational culture were key factors in the GP Super Clinics, in particular in relation to perceptions of clinicians and patients. This aligns with international evidence in health and other organisations which emphasises leadership and organisational culture as strong drivers of performance and innovation.[27] In a study focusing on change in primary care in the United Kingdom towards the establishment of Primary Care Medical Homes, leadership from both physicians and practice managers drove the change process.[74] Similarly the results of this evaluation show the GP Super Clinic Directors or clinical leaders, in collaboration with the practice manager, driving the models of care.

Organisational culture, and in particular, relationships among all members of the health care team, have been demonstrated to be associated with health outcomes, particularly those associated with chronic disease management.[31,75] Not surprisingly, clinicians and administrative staff clearly articulated the importance of the culture, driven by the leadership of GP Super Clinic Directors, and supported by clinicians, as a critical factor in the models of care. Indeed, a number of the GP Super Clinics had recruited specifically on the basis of attributes of teamwork and commitment to the model of care. Conversely, a number reported that where staff turnover had occurred it was commonly because of inability to work as a member of a multi-disciplinary team.

The importance of leadership in the GP Super Clinics' model is also an inherent risk. In the absence of clear succession planning, problems could occur with service delivery under the agreed model if change in leadership occurs. This needs to be recognised within GP Super Clinics and succession planning supported within the Department of Health and Ageing.

### 7.4.3 Alignment between Clinical and Business Model

The two Program objectives which appeared to dominate in determining the focus of the GP Super Clinics were those related to the provision of multi-disciplinary care and the viability of the business model. In a business sense this is understandable, equating to ensuring the product and price achieve targets. Moreover, there appeared to be a genuine commitment by the majority of GP Super Clinic Directors, to the opportunity to provide multi-disciplinary care under this new model. However, it was recognised that the GP Super Clinics had to be financially sustainable, not only because it was one the Program objectives, but, possibly more importantly, because it was essential for recruitment and retention of the clinicians. Achieving a balance between driving the model of care and the financial model appears critical to the success of the GP Super Clinics in achieving all Program objectives.

### 7.4.4 Assessing Impact and Outcomes

The electronic health record was most commonly used clinically for individual patients. It was cited also by the majority of clinicians as an important facilitator of multi-disciplinary care. However, it was used less as a tool for organisational, administrative and quality improvement roles within the GP Super Clinics. This is a missed opportunity both within GP Super Clinics and across the GP Super Clinics Program. The potential for use of and linkage with data to measure performance, drive quality and determine achievement of the GP Super Clinics Program objectives exists, but has not been fully exploited. Reasons for this may relate to priorities and knowledge of the system and its use within GP Super Clinics. The potential for linkages and performance reporting could be further explored across the system.

### 7.4.5 Differences in Organisational Models

Organisational models in primary care have been demonstrated to impact on performance.[76] Criteria to assess performance included those related to patient experience, access, population coverage, response to vulnerable clients and a range of productivity measures.[76] Models of primary care which had population-based responsibility, strong integration into health network activities, a broad range of services and access through walk-in clinics or by appointment performed better against all criteria than other models.

All GP Super Clinics participating in this aspect of the evaluation provided multi-disciplinary care despite differences in the organisational and business models. Variations in structure, ownership and business models were noted. The *GP Super Clinics National Program Guide 2008* was deliberately flexible in describing the requirements for the organisational, business and service delivery models. This has proved critical in attracting a variety of applicants, who have demonstrated both a commitment to the models of care, and the adoption of business models to ensure a sustainable approach to enhanced primary care in the local communities.

The organisational model which appeared to have the most difficulties was where there was a third party contract arrangement. This occurred where a state health service was the successful

applicant for the GP Super Clinic but sub-contracted that arrangement to a third party or where the funding recipient split asset holding and operational entities to mitigate risks to ownership of the property asset should financial viability be an issue. As in any third party contractual arrangement, this model has inherent risks which need to be identified and managed, particularly in instances where the contractor's objectives and those of the GP Super Clinics Program may not totally align. This was further complicated by the indirect, third party communication and reporting arrangements between the GP Super Clinic and the Department of Health and Ageing, which in the opinion of the evaluation team was ineffective and inefficient.

### 7.4.6 Recommendations – Learnings from the GP Super Clinics Program

These recommendations relate to learnings from the GP Super Clinics Program beyond the program objectives

27. The GP Super Clinics should develop strategic plans within the framework of the GP Super Clinics Program. Their development should be required to be part of the reporting requirements of the GP Super Clinics Program. The format and content should be determined by the GP Super Clinics but should reflect priorities outlined in 7.3.11
28. Further evaluation of the Program should be explored when all GP Super Clinics have been operating for at least three years. Evaluations should focus on patient outcomes and experiences, the models of care in relation to evidence, and clinician outcomes and experiences.
29. Negotiation should occur between the Primary and Ambulatory Care Division and medical software businesses, to determine the potential for linkage between this software and reporting requirements of the GP Super Clinics Program and potentially other primary health care services.
30. The Department of Health and Ageing should critically review any third party contractual arrangements to review the alignment with GP Super Clinics Program objectives among all parties. Where this alignment does not exist, the renegotiation of the contract should commence. Where alignment exists, procedures should be implemented to ensure direct communication between the GP Super Clinics, and the Department of Health and Ageing.

## 7.5 Primary Health Care System Learnings

In addition to the GP Super Clinics there is a range of other reforms and investment in general practice and primary health care, presently in existence:

- Establishing Medicare Locals across Australia, to work with the full spectrum of general practice, allied health and community health care providers, improve access to care and drive integration among services

- Ensuring that communities will have access to GP advice and services after hours, with the capacity to put Australians in contact with GP services in their communities when needed

Some of the learnings identified in this evaluation are not specific to the GP Super Clinics Program and are thus outside the scope of this evaluation. However, they have implications for

the broader primary health care system and thus have potential to be considered in the context of these reforms.

### 7.5.1 Measuring Primary Health Care Performance

Measuring the performance of the primary health care system is important, for a number of reasons. From a democratic perspective, return on investment of public money should drive performance measurement. Performance data also allow a more thorough understanding of primary health care and enable system and service improvements.[77] Primary health care performance data also have the potential for broadening the public debate on health care, one which is dominated by acute care, in part because of availability of data on hospital-related issues.[78]

There is considerable debate about how to capture accurately the breadth and complexity of activity and outcomes in primary health care. However, in their absence the ability to build improved primary health care systems is limited.[78] A number of developed nations have been struggling with the challenge of measuring performance in primary health care.[79] Both the United Kingdom and Canada have progressed performance measurement through systems such as the Quality Outcomes Framework (United Kingdom) and the Pan-Canadian Primary Health Care Indicators project. In addition to measuring impact and outcomes these systems also measure patient experiences.[80]

Specific indicators are only now being considered for application across the GP Super Clinics Program. These indicators understandably are program-specific. They will enable assessment of the extent to which the models of care and activities of the GP Super Clinics achieve the GP Super Clinics Program objectives. They do not, nor are they intended to, provide an assessment of the activity and outcomes associated with this model of care. Clinicians expressed frustration at the lack of systems to provide robust and comparable activity and outcome data, but also recognised that this was a system rather than a GP Super Clinics issue. The processes being developed as part of the delivery of the broader health reforms and in particular the National Health Performance Authority may consider the measurement of broader primary health care systems and outcomes.

### 7.5.2 Medicare Benefits Schedule

The MBS primary care items support a range of primary care services. [81] These items now allow GPs to refer patients with complex, chronic illnesses to other disciplines for up to five subsidised services per patient per annum and provide financial incentives for general practitioners to coordinate the care of a patient with a chronic condition with at least two other care-givers.[82]

The MBS items have been consistently raised as barriers to the success of multi-disciplinary care in the GP Super Clinics. In particular, it was perceived that there was inequity in access to MBS items between GPs and allied health staff. Claims for more equity in provision of financial incentives for allied health and nursing staff were raised consistently, particularly in relation to case conferencing.

Policy changes to MBS items are difficult in the context of limited evidence on patient outcomes and on the provision of effective multi-disciplinary care.[42] The GP Super Clinics Program cannot address this problem. Rather, it is a broader health and primary care system problem which

needs to be viewed in the context of evidence for achieving patient and population health outcomes, and effective multi-disciplinary care.

### 7.5.3 Role of the Universities

Primary health care is increasingly focused on the provision of chronic care illness under a multi-disciplinary care model. The capacity to continue to provide this model of care will, in part, depend on the training of future health professionals. One of the GP Super Clinics Program objectives relates to teaching and training of health professionals. Most of the GP Super Clinics have developed or are developing relationships with universities. Indeed, some have structural relationships and co-location of academic units with the GP Super Clinics. This is expected to facilitate a partnership approach to teaching and training of students in various disciplines.

Where relationships have been established between GP Super Clinics and universities, they appear to mostly one-way relationships. The GP Super Clinics have enabled the universities to provide much-needed placements for under-graduate students in a multi-disciplinary environment, which is consistent with the GP Super Clinics Program Objectives.

However, it does not appear to have changed the way students are trained in the university settings. It has been argued that teaching students at under-graduate level the importance of and skills in working in a multi-disciplinary environment means greater potential of application in their clinical experience.[83] On return to the universities, students still undertake single-discipline learning which does not necessarily reflect patient profiles or future models of care under which they will provide services.

It is recognised that there are logistical difficulties for universities in introducing inter-professional education into the curricula. While single discipline teaching is obviously needed at times, there are many opportunities, such as through problem-based learning, where inter-professional learning could occur. Similarly, gaps between models of care for primary care and, in particular, chronic disease management and post-graduate training have been identified.[84]

The relationships between the GP Super Clinics and universities are in their infancy, and examples of teaching, training and research partnerships were not evident beyond co-location and provision of clinical placements. There are opportunities for universities and relevant colleges to show much greater leadership in teaching and training of health disciplines to reflect the demands of 21st century primary care practices than has been demonstrated in this evaluation. This will require a fundamental rethink of the way multi-disciplinary education can be provided in a way which more closely mirrors modern health care practice thus challenging the status-quo in current programs. Universities should be challenged as to why much of their problem-based learning approaches still occur in discipline silos, thus further perpetuating the silo mentality of health care.

Similarly, there are opportunities through partnerships with GP Super Clinics to undertake research with members of teams, where clinics are not merely points for data collection, but are places where questions can be determined collaboratively and research which meets needs of modern practices can be undertaken. Through a collaborative approach there is an opportunity to answer questions of relevance to patients, clinicians and policy makers in relation to primary care.

**Key Learnings – Primary Care System**

31. If there is a commitment to increasing investment in primary health care by the Australian Government, measurement of its performance through efficient systems and robust data is required to determine return on investment and to drive quality through improvement of the system and services.
32. Universities and relevant discipline-specific colleges should be encouraged to review their models of teaching and training to reflect the realities of modern day primary care.

## 7.6 Strengths and Limitations

This evaluation attempted to assess three aspects of the GP Super Clinics Program: the implementation, establishment and operations aspects.

The results of the evaluation should be interpreted within the limitations of the methods. Samples in patient and clinicians surveys which provided quantitative data were volunteer samples suggesting caution in attempts at generalisation. General practitioners completing the survey represented 55% of participants in the clinician survey while representing 42% of the FTEs employed in the seven clinics. The higher proportion of GPs responding the survey is likely to cause biases in results. Patient selection was potentially influenced by reception staff and is thus another source of bias.

The community stakeholders selected for the interviews were provided by the GP Super Clinic Directors. These were those that had worked with the GP Super Clinics in their early stage of their development. The small numbers that participated in interviews, and that they were identified by the GP Super Clinics is a further limitation of the evaluation. The evaluation did not and did not intend to capture broader views of stakeholders.

The results of the surveys were complemented by and aligned with results of interviews held with a large number and diverse range of clinicians and patients. A process of thematic analysis was used to identify common themes to optimise rigor in the qualitative data.

Despite these limitations, many of the results accord with those identified empirically. However, the GP Super Clinics Program is in its infancy and will require time before more robust evaluation to assess outcomes can be applied.

## 7.7 Conclusion

This GP Super Clinics Program is fundamentally a reform program. It is a reform program aiming to change the way primary care is delivered in Australia. These reforms align with those internationally. Reform by its very nature means change; change to the status quo, change to structures and organisations, and changes to the way people – in this instance clinicians, patients and the community - behave.

With change comes resistance. However, these reforms are ultimately about patients, the quality of patient care and the ability to meet community needs. While the Program is in its infancy, this evaluation suggests that ultimately patients are being enabled to access multi-

disciplinary primary health care, in buildings that support patients and staff, in an environment where care providers are working collaboratively and where care is well-supported by the use of electronic health records.

The GP Super Clinics Program is, has been and will continue to evolve. This also is in line with reform programs. Part of the evolution in the GP Super Clinics Program should arise from other reforms in primary care occurring concurrently. Maximising these opportunities for aligned evolution with the range of reforms is a key responsibility for the Department of Health and Ageing, for the GP Super Clinics and for the raft of other reform programs.

# 8 Appendices

## 8.1 Appendix 1: GP Super Clinics Program Objectives

1. GP Super Clinics will provide their patients with well integrated multidisciplinary patient centred care. GP Super Clinics will support their patients, particularly those with, or at risk of, chronic disease(s), with the option of receiving the full range of health services they need in a coordinated manner, where possible and appropriate, in a single convenient location. Underpinning this care will be integrated models of clinical governance and shared care protocols, as well as a strong focus on supporting patient self-management.

2. GP Super Clinics will be responsive to local community needs and priorities, including the needs of Aboriginal and Torres Strait Islander people. Ensuring GP Super Clinics address local needs and priorities and have local community support will be a key element of the establishment process. As part of a demonstrated long term commitment to local health care services, organisational governance arrangements for the clinics will need to provide for ongoing community engagement and input.

3. GP Super Clinics will provide accessible, culturally appropriate and affordable care to their patients. While health professionals will retain their autonomy over billing, GP Super Clinics will be strongly encouraged to bulk bill Medicare Benefits Schedule funded services.

4. GP Super Clinics will provide support for preventive care, including promotion of healthy lifestyles, addressing risk factor and lifestyle modification to prevent chronic disease and improving early detection and management of chronic disease.

5. GP Super Clinics will demonstrate efficient and effective use of Information Technology. This would include an electronic clinical information system that can make patients' medical records available (with patient consent) to all practitioners (including allied health professionals) at the GP Super Clinic and to external providers as appropriate.

6. GP Super Clinics will provide a working environment and conditions which attract and retain their workforce. This could entail a range of models, including scope for health professionals to contribute clinical sessions and teaching activities, possibly on a salary basis, without needing to consider routine administrative and practice management activities. As workplaces of choice, GP Super Clinics will also provide support for primary health care research to complement clinical service delivery.

7. GP Super Clinics will be centres of high quality best practice care and will be expected to meet industry accreditation standards, including accreditation against the Royal Australian College of General Practitioners' Standards for General Practice (3rd edition), and accreditation for training, where this is applicable. Where appropriate, GP Super Clinics would also be encouraged to participate in the Australian Primary Care Collaboratives Program.

8. Post establishment, GP Super Clinics will operate with viable, sustainable and efficient business models, drawing revenue from existing programs and initiatives (including provision of health services under usual fee for service arrangements), and potentially other sources such as community partners.

9. The GP Super Clinics program will support the future primary care workforce by providing high quality education and training opportunities supported by infrastructure for trainee consulting rooms, teaching rooms and training facilities to make general practice attractive to students, new graduates, GP trainees and registrars and other health professionals.

10. GP Super Clinics will integrate with local programs and initiatives, demonstrating enhanced co-ordination with other health services and a partnership approach to local health service planning and coordination. This will further strengthen local general practice and the broader local primary health care services

## 8.2 Appendix 2: Primary and Secondary Evaluation Questions

### 8.2.1 Implementation Aspect Evaluation Questions

**Primary Evaluation Questions**

1. Why was the GP Super Clinics Program introduced?

2. How was the GP Super Clinics Program implemented by the Department of Health and Ageing? How did it comply with the regulatory requirements of the Australian Government? How well did it comply with the *GP Super Clinics National Program Guide 2008*?

3. How has the Program developed over time?

**Secondary Evaluation Questions**

1. What was the policy context underpinning the GP Super Clinics Program?

2. How were local communities and stakeholders engaged during the implementation of the Program?

3. What were the regulatory requirements of the Australian Government for the implementation of the Program? How well did the Department comply with these?

4. How well did the Department comply with the *GP Super Clinics National Program Guide 2008* that it established for the Program?

5. How well did the Department communicate with interested parties and stakeholders about the implementation of the Program?

### 8.2.2 Establishment Aspect Evaluation Questions

**Primary Evaluation Questions**

1. What were the processes used by GP Super Clinic funding recipients to assist with the construction phase to ensure timeliness and cost-efficiency? What were the benefits or challenges of these processes and how did they impact on construction?

2. What external influences affected the timeliness and cost-efficiency of the construction work?

3. In what way have the completed buildings assisted GP Super Clinics in meeting the operational requirements for the Program?

4. To what extent does the establishment phase represent value for money (in terms of cost per square metre compared with comparable infrastructure for investment in primary care)?

**Secondary Evaluation Questions**

1. What were the processes used for and timeliness of land/property acquisition? How did these vary across sites? What factors impacted on land/property acquisition and zoning?

2. What factors and requirements of local government impacted on the approval of and timeliness of gaining development consent? How did these factors and requirements impact on the timeframes for construction? What were the processes used and timeliness in relation to gaining local government Notice of Consents? How did these vary across sites?

3. What processes were used to assist with the construction phase to ensure timeliness and efficiency? How did these vary across sites? What were the benefits to or challenges of these processes and how did they impact on construction?

4. What processes were used to ensure that the construction phase could be delivered within budget and achieve value for money? How did these vary across sites? What factors impacted on these processes?

5. How well did the construction phase comply with contractual requirements between the builder and the funding recipient? Why? How did these vary across sites?

6. How well has the completed building met the expectations of the operational requirements and the users of the building? How and why has this varied across sites?

7. How do the costs of construction of buildings, surrounds, furniture, fixtures and equipment and the gross floor area for the GP Super Clinics compare with comparable cost models?

### 8.2.3 Operations Aspect Evaluation Questions

**Primary Evaluation Questions**

1. How well have the differing operational models (service and care) achieved each of the ten objectives of the GP Super Clinics Program? What elements of these models have assisted, or posed challenges?

2. How well have the differing operational models (service and care) addressed the key performance indicators for the GP Super Clinics Program? What elements of these models have assisted, or posed challenges?

**Operations Aspect – Secondary Evaluation Questions**

Each of the secondary evaluation questions for the operations aspect addresses a specific objective of the GP Super Clinics Program

1. What is the range of health professionals who deliver services within the GP Super Clinics?

2. What principles, practices and/or processes underpin each of the operational clinics assist them achieve integrated, multidisciplinary, team based approaches to care?

3. How do the models of care in the operational clinics identify, monitor and address the specific needs of local communities including, as appropriate, Aboriginal and Torres Strait Islanders and older Australians in Residential Aged Care facilities and community based settings?

4. What mechanisms are used for engaging with the local community and how does this impact on service delivery?

5. How do the clinics address the accessibility of primary health care services, especially with regard to after-hours services?

6. How do the clinics address the issue of affordability of primary health care services, especially with regard to bulk billing?

7. What are the clinics doing to address the cultural and linguistic needs of the populations within their local community?

8. How do the patients at the clinics perceive that questions 1-3 above are being addressed?

9. How do the service and care models in each of the operational clinics support increased capacity for preventative care?

10. How do these models extend the traditional roles and responsibilities of the non-GP staff?

11. What benefits for patients have resulted from this increased focus on preventative care?

12. How have the operational clinics maintained the viability and sustainability of their models whilst providing the preventative services?

13. How have the IT systems in the operational clinics been developed to support an integrated, multi-disciplinary, team based approach to primary health care?

14. How well are the health professionals in the operational clinic using these systems to provide integrated, multi-disciplinary, team based care?

15. What has been the approach to the availability of a shared patient record for health professionals in the clinic?

16. How well have these systems met consumer privacy requirements?

17. How have these systems been used to extend clinic services beyond the clinic?

18. How have the operational clinics created a working environment that attracts and retains primary care professionals? What obstacles have they encountered?

19. What strategies are being utilised by the operational clinics to recruit and retain the workforce? How well have these worked?

20. What are the strategies used by the operational clinics to ensure high quality care that reflects best clinical practice?

21. What arrangements are in place to obtain accreditation of the clinics?

22. Have there been any implications of the multidisciplinary model of care for gaining accreditation? If so, how have the operational clinics addressed these?

23. What are the key elements required for achieving a viable, sustainable and efficient business model?

24. What have been the challenges and achievements in maintaining such a business model?

25. How do the operational clinics contribute to the education/training of undergraduate medical, nursing and allied health students and registrar GPs?

26. How well do these placements provide opportunities to experience working in an integrated, multi-disciplinary, team based environment?

27. How well does the physical environment support this training?

28. What are the barriers to increased participation in education/training of the future primary care workforce?

29. How many of the operational clinics are accredited training facilities for GPs?

30. What mechanisms have been established to support shared planning and coordination with other local health service providers?

31. What are the barriers/enablers to shared responses to planning and coordination with other local health services providers?

32. What arrangements are in place for the delivery of state/territory funded services from within the operational clinics?

33. What are the barriers/enablers to locating/improved cooperation/coordination with state/territory funded services from within the operational clinics?

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