AUDIT OF THE RELATIONSHIP BEWEEN DIVISIONS AND THEIR COMMUNITY

2001 RESULTS

BACKGROUND

In 1999/2000, GPDV provided Victorian divisions with a self-audit to assist them with reviewing and reporting on the extent of their relationship with their communities, and the involvement of consumers in program planning and management generally.

In 2001, GPDV offered a second self-audit and extended its focus. Using the results and recommendations presented below, Victorian divisions will be able to reflect upon their models of consumer and community engagement, and focus on continuing growth in developing models of best practice.

2001 AUDIT DESIGN

The 2001 audit questionnaire was presented in four parts:

PART ONE allowed divisions to check the extent to which the community has had input to the division's information gathering, decision-making, program delivery and evaluation for 2000 - 2001. Divisions were asked to simply tick a box to indicate involvement. If they were unsure how to judge whether or not to award a tick, divisions were asked to imagine an independent researcher asking that person/group/organisation whether they had provided input into the division's information gathering or decision-making. If the answer would be "yes", a tick could be awarded.

PART TWO provided a checklist of ways in which divisions have contributed to information gathering and decision making by other stakeholders in the community for 2000 - 2001.

PART THREE identified features of divisions' Consumer Advisory Groups or their equivalent.

PART FOUR encouraged a broader discussion about divisions' experiences of community involvement in division activities. Divisions were asked to respond to a series of explorative questions about division policies, the role of consumer/community organisations in divisions' work, changes in the way consumers have been engaged, and future plans.

RESPONSE RATE

Division location	Total in sample	Total in Victoria
Metropolitan	13	16
Provincial	3	3
Rural	7	12
TOTAL	**23**	**31**

Range of annual division income from DH&AC Divisions Program	Total in sample	Total in Victoria
BAND 1: < $300,000	0	1
BAND 2: $300,000 - $399,999	7	9
BAND 3: $400,000 - $499,999	7	9
BAND 4: $500,000 – 599,999	2	4
BAND 5: > $600,000	7	8

Though the response rate for rural divisions was 58%, those divisions that responded were well spread across income bands 2, 3, 4 and 5. The divisions in the sample therefore appear to represent a cross section of divisions in Victoria both in terms of geographic location and size.

Accepting the sample as appearing to be representative, the audit shows that Victorian divisions have continued to use a wide variety of strategies to involve themselves in health planning within their local communities and to involve other stakeholders in the design and delivery of division programs.

RESULTS – PART ONE
COMMUNITY INVOLVEMENT

Definitions

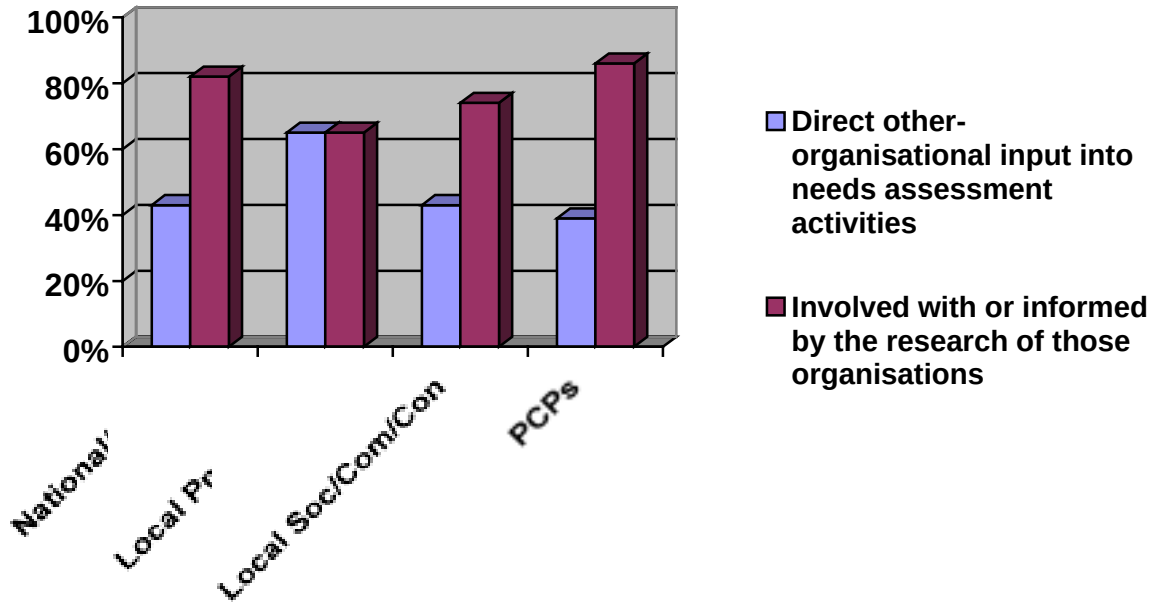
National or state organisations include the Department of Human Services, tertiary education bodies, disease-specific or age-specific organisations, government-funded bodies (eg the National Prescribing Service) and government-affiliated bodies (eg the HIC).

Local Primary or Acute Health organisations include community/mental health services organisations, other local service bodies (eg alcohol and drug support organisations), pharmacists, and hospitals or hospital networks.

Local Social/Community Support and Consumer organisations include local governments, schools, resource centres, carers groups, consumers from organised consumer groups, and individual (unaffilitated) consumers.

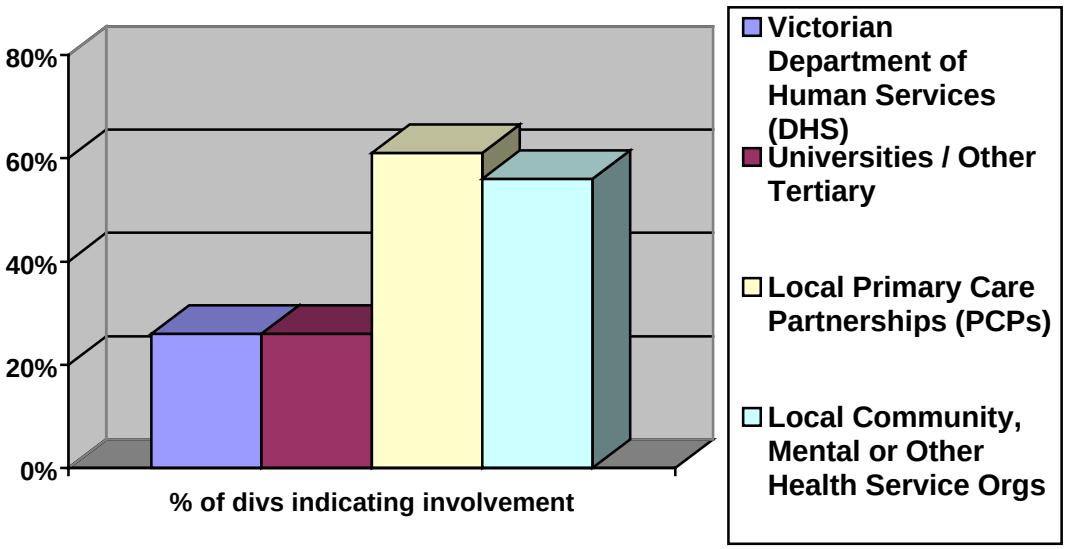
(a) Needs assessment

Divisions were asked to indicate whether other organisations had input into their needs assessment activities. They could indicate either direct input, indirect input through those organisations' research activities, or no input. The results show significant other-organisational input into divisions' needs assessment activities:



(b) Strategic planning group activities

In addition to contributing to needs assessment, 74% of divisions indicated the involvement of external organisations during the strategic planning phase. Various types of organisations had been consulted:



(c) Membership of groups convened by the division

35% of divisions indicated that other organisations had been members of the division's board of management or equivalent. This included one rural and four metro divisions that had consumers from

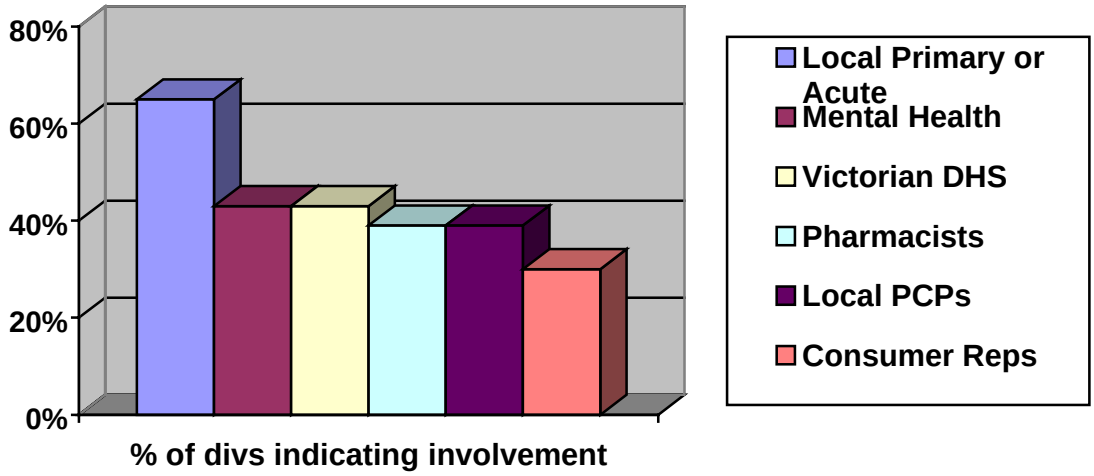
organised consumer organisations as members of their boards. 43% had external organisational representatives as members on their program advisory groups, and for reference groups or advisory groups for specific program areas the number was 78%.

48% of divisions indicated other organisational representation on their consumer/community advisory groups (or equivalent). Of these 48%, 73% had representation from organised consumer groups or unaffiliated consumers, and 82% included representation from other organisations, particularly community health and local area service networks.

17% of division indicated that they had no external representation on any of their convened groups.

(d) Ongoing involvement in program delivery through divisions' programs

In total, 87% of divisions indicated ongoing involvement by representatives of external organisations in program delivery. Divisions indicated that a range of organisational types had been involved:



Other interesting statistics include:

- Seven divisions indicated extensive other-organisational involvement, including the involvement of national/statewide, local primary/acute, local social/community and PCP organisations;
- one had involved only their local PCPs; and
- three indicated no ongoing external involvement.

(e) Participation in evaluation of the divisions' programs

70% of divisions indicated external involvement in their program evaluation design and supervision. Particularly prevalent was the involvement of universities or other tertiary education bodies, national government/non-government or local organisations such as carer's groups or migrant resource centres (35%) and consumer representatives (26%). Only one of the twenty-three divisions had involved their local PCP in program evaluation.

This figure rose to 78% when divisions were asked whether external organisations had been involved in giving direct input via an interview, survey, or focus group. 39% of all divisions surveyed had received input from local community or mental health organisations and 26% had received input from

either state-wide organisations or the Department of Human Services. However, no divisions had involved consumer representatives in this manner.

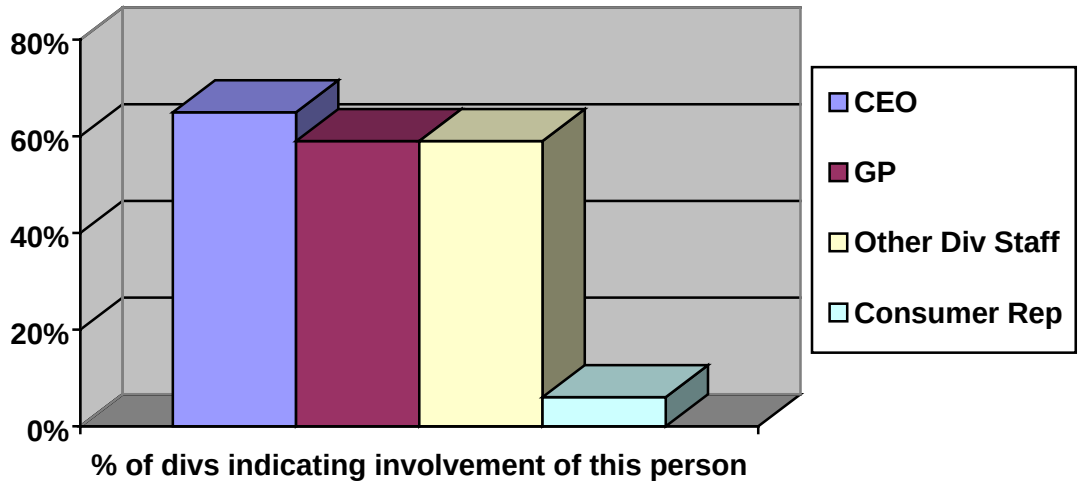
57% of divisions indicated that they had had other organisations conduct evaluation on their behalf – through surveys, interviews, or GP audits. For example, 35% used universities or other tertiary education bodies in this manner and 17% used community health services to conduct evaluation. No divisions had used PCPs in this manner, though 13% had involved the Department of Human Services.

RESULTS – PART TWO
LINKAGES WITH STAKEHOLDERS

(a) Linkages: Municipal Health Planning Groups

- 74% of division had these linkages

Most of these linkages were council or shire run planning groups, and most divisions indicated that they had developed a working relationship to the extent that both they and the municipal health planning group were at least better informed about their respective activities. 29% of these had specifically allocated at least two hours per week to these groups. Of the 74% indicating involvement, the type of divisional representative involved was mixed:



41% of the linked divisions said that they had taken joint action with the municipal health planning group and 29% claimed to have modified the practices of the other service provider.

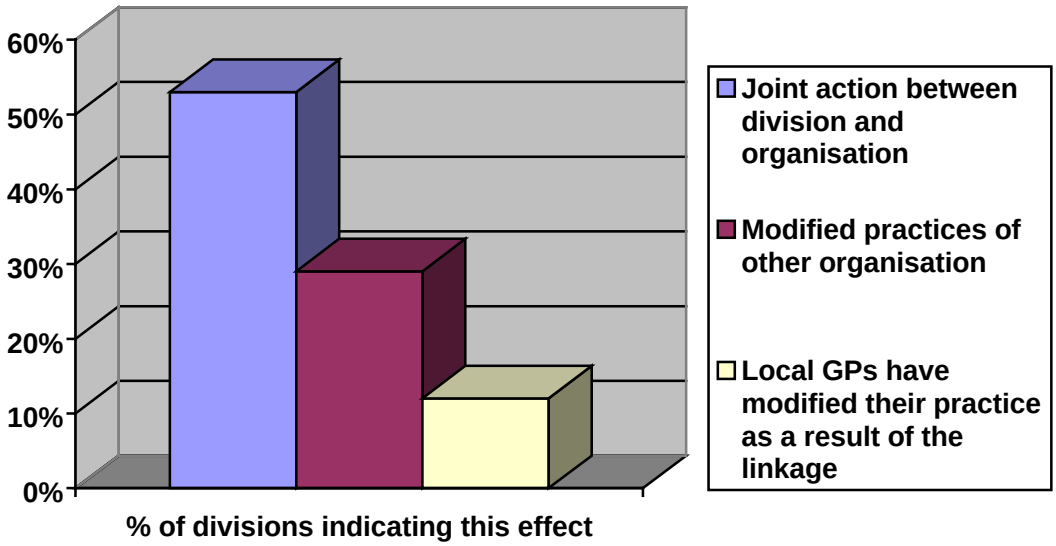
(b) Linkages: Regional Health Planning Groups

- 74% of division had these linkages

Most of these linkages were based on staff participation in health promotion networks, though some were based solely upon category-specific networks such as mental health, immunisation or PCP alliances. Only 24% of divisions with these regional linkages had specifically allocated at least one

hour a week to participation. Of these 24%, 75% had allocated staff time whilst 25% had allocated combined CEO and GP time.

The development of relationships and their effects were generally stronger than those for the municipal health planning groups. Divisions with regional linkages indicated that they had had the following effects:



(c) Linkages: Primary Mental Health Teams

- 78% of divisions had these linkages

Of those that have reported linkages, 72% describe the linkage as on-going and developing (57% of all surveyed). 50% with linkages had dedicated at least one hour per week to the relationship, and there was strong participation by GPs and CEOs (44% of those with linkages or 35% of all divisions surveyed), division staff (89% / 70%) and GPs (67% / 52%). Consumer input into the relationship was limited to just one division. 78% of divisions with these linkages reported that they are in the developmental stage. 28% said the relationship had led to joint action, and only one division reported that GPs had changed their practice as a result of the linkages.

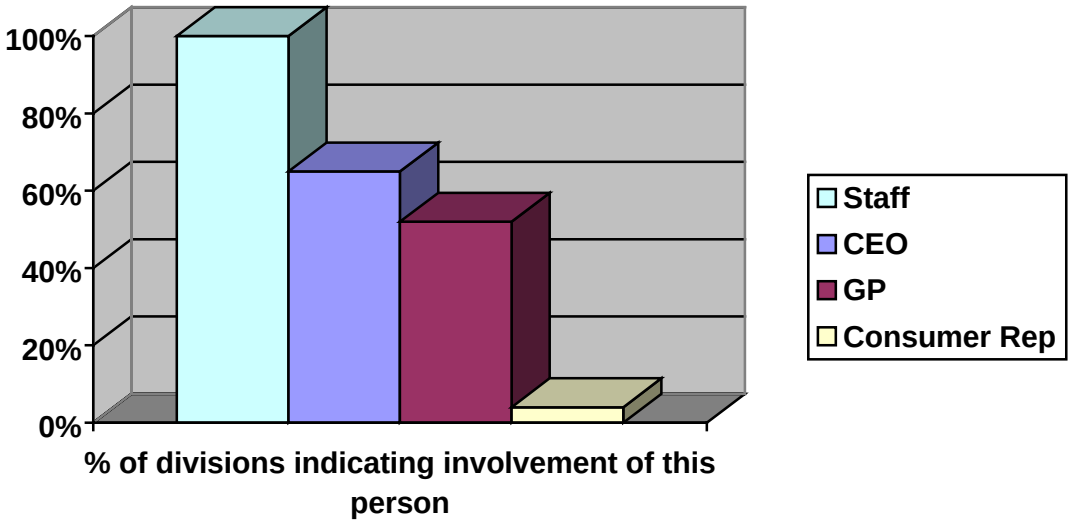
(d) Linkages: Primary Care Partnerships

- 100% of divisions surveyed had these linkages

Linkages with Primary Care Partnerships have been established across all 23 divisions surveyed, and in 15 of those divisions there was more than one linkage reported[1]. 65% of divisions had dedicated at least one hour per week to their PCP relationships, with 35% dedicating at least 3 hours per week.

[1] In many cases, this is because divisional and PCP boundaries are not aligned, so that divisions have to establish relationships with anywhere from one to four PCPs. In other cases, divisions reported linkages with planning/program groups within PCPs: for example, health promotion sub-committees or IM/IT working groups.

Divisions were involved in all division-PCP relationships, and in the following way:



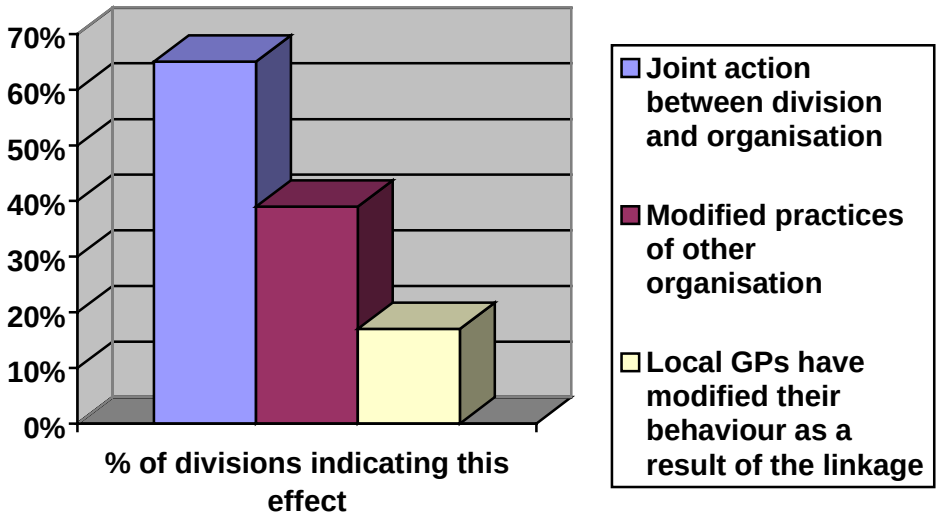
The low participation rate of divisions' consumer representatives in ongoing PCP committees is expected. PCPs are required to develop and implement a consumer engagement strategy, and many developed reference groups and consultation mechanisms as part of their strategy. Because of this, divisions may have felt that consumers of general practice services are already adequately participatory in the PCP strategy. Also, PCPs may have consulted independently with divisional consumer representatives; this type of consultation would not be captured by this survey.

Note that the survey also revealed that 53% of divisions with Consumer Advisory Groups (CAGs) had somehow involved their CAG in the PCP initiative. This seemingly contradictory result may indicate that CAGs had at least talked about consumer engagement in relation to PCPs, though did not see the need for direct involvement given existing PCP consumer engagement strategies.

The high level of participation by GP representatives is noteworthy. Possible explanations include the commitment that GPs have to ensuring that they are part of primary care reform processes. Also, the profile given to GP engagement in the PCP Strategy by DHS and DoHA, and the support and advocacy role played by GPDV promoted representation within the PCP as the priority mechanism for framing division work on primary care integration. In addition, Divisions consistently identified cultural differences between general practice and the DHS funded sector/allied health providers as a key barrier to effective communication and coordination of services. Having GPs at the table with other providers may have been a strategy to promote better understanding between general practice and allied health practitioners about roles and practices in assessment and treatment.

Though 91% of divisions surveyed reported that relationships with their affiliated PCP/s were still developing, 65% indicated that joint action had occurred, and 87% reported that both organisations were better informed as a result of their collaboration.

As a result of division-PCP collaboration, divisions reported the following positive results:



(e) Linkages: Membership on Other Management Boards, Program/Service Advisory Groups and Working Parties or Reference Groups

52% of divisions were represented on the boards of management of other organisations, ranging from PCPs (13%) to community health centres (22%) to national and state-wide health organisations (13%).

Membership on program or service advisory groups was strong, with 87% of divisions linked with other organisations in this way, mostly through GP reps (57%). The types of advisory groups that these divisions belonged to ranged across the spectrum, from PCP subgroups (22%), state health advisory groups (52%), local government or non-government service advisory groups (30%) and others. 30% of divisions had allocated at least one hour per week to working in these types of groups.

74% of divisions also reported membership on working parties or reference groups, mostly through staff and/or GP representation. The types of groups that divisions were represented on were hugely variant – from workforce agencies to committees dedicated to health weeks (eg: mental health week) to government task forces to hospital working groups. Only 29% of divisions with reps on these committees had committed at least one hour per week to their functioning, which reflects their temporary nature.

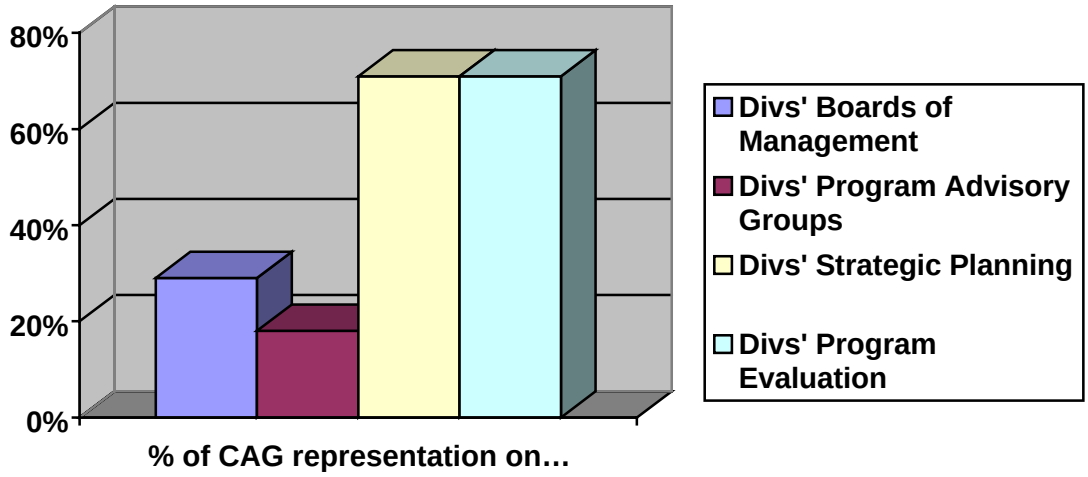
RESULTS – PART THREE
ROLE OF CONSUMER /COMMUNITY ADVISORY GROUPS

- 74% of divisions indicated that they had a Consumer Advisory Group (CAG) or equivalent

Of these 74% of divisions with CAGs:

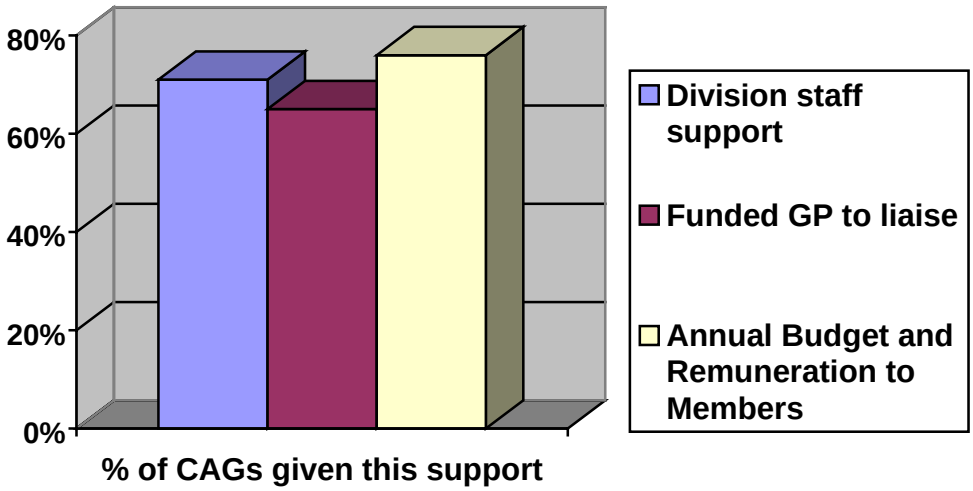
- 82% had terms of reference for their CAGs that had been agreed by their board
- 65% had CAGs that received copies of relevant divisional background papers and/or board minutes

When asked if members of their CAGs were represented on other division planning and evaluation groups, divisions responded thus:



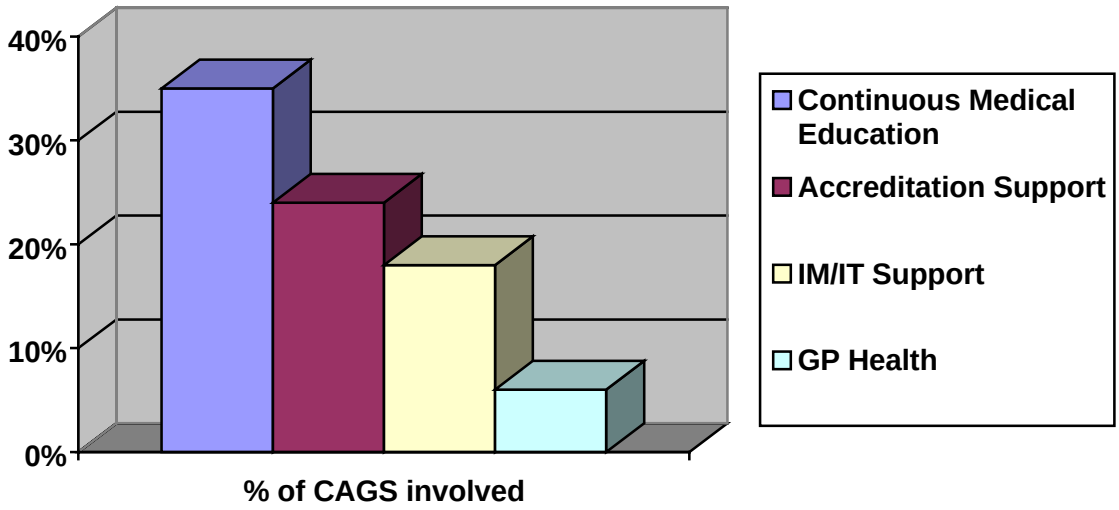
Of the 29% of CAGs represented on divisions' boards of management, 13% had voting rights. Just 6% of divisions with CAGs answered yes to all four questions relating to representation.

Resource support for CAGs from the division was indicated in the following way:



71% of divisions with CAGs provided a % of EFT staff time to support the CAG, whilst 65% funded a GP to liaise with them. 76% of divisions provided their CAG with both an annual budget and offered remuneration to its members, whilst 12% offered neither.

Divisions with CAGs confirmed the following CAG involvement in GP services:



Additionally, 35% of divisions with CAGs reported CAG involvement in the writing of funding submissions.

CAGs were also involved in primary care, health promotion and illness management initiatives. Of the divisions with CAGs:

- 41% indicated that their CAG was involved in the Enhanced Primary Care (EPC) initiative;
- 53% in PCPs;
- 29% in both diabetes and cardiovascular disease initiatives;
- 18% in asthma initiatives;
- 29% in mental health initiatives; and
- 53% in patient education.

Five divisions had involved their CAGs in at least three of these specific areas.

RESULTS – PART FOUR
EXPLORATIVE QUESTIONS

(a) Consumer Involvement Policies

- 43% of divisions indicated that they had consumer involvement policies.

There was some confusion with this question – some divisions responded that the involvement of consumers in needs assessment or program delivery indirectly demonstrated a "policy". However, the survey was seeking to establish the percentage of divisions that had written policies.

Most divisions without a written policy stressed their strategic commitment to consumer/community involvement and consultation.

(b) Board Responsibility For Community Health

Some divisions emphasised that as their Board was comprised of GPs, and that general practice attempts to meet the health needs and demands of their own community, it was self-evident that their Board felt a keen responsibility. Others referred to their division's mission statement (eg: "to enhance the health of the community and the role of general practice in this process") to show that it was the Board's job to connect to and feel responsible for their community's health. Others provided specific examples of consumer input and community involvement in the development of their division's priorities.

A provincial division summed up this question in the following way:

> "Members of the… board are GPs living and working in regional cities and small rural towns. They are individually, therefore, members of their own local communities. They spend their professional lives committed to enhancing the health of members of the communities they serve. As professional physicians, Board members demonstrate their commitment by getting their practices accredited, regularly updating their qualifications and undertaking professional development, implementing the most current practices in the field, and enthusiastically embracing the initiatives of state and federal government for the ongoing benefit of both consumers and ultimately the communities".

(c) Roles/Priorities for Consumers/Community in Divisions' Work

Here, divisions were asked "What is the appropriate role for consumers and the community in division's work?" They were then asked to prioritise the most important to the least important, and to provide some explanation of the reasons behind their ranking. Results from this question are summarised below from the most frequently mentioned priority to the least. The most appropriate roles identified were:

1. As a reference or active participant in the strategic planning phase
2. As a reference or active participant in the program development and delivery phase
3. As a general reference for division activities
4. As a support for general practitioners in terms of lobbying for funds, and for marketing purposes
5. As a force to help persuade GPs to more keenly adopt a population health or health promotion focus
6. Roles need to be limited – though Boards are supportive of consumer input, they are uncomfortable with representation at the Board level for a variety of reasons eg: maintaining privacy of patient details, non-professional status
7. As a reference or active participant in the program evaluation phase
8. As a force to help persuade GPs to focus upon the health of specific sub-populations such as Aboriginal and Torres Strait Islanders, youth, and specific gender-related issues.

Judging by the breadth of comments on this question, it is apparent that many divisions have already given it a great deal of thought. One division stated that their Board's perspective differed from their staff's perspective:

> "Board perspective: that consumers should inform some of our activities. That consumers have an important role to play in the evaluation of our programs, [and] that consumer involvement with the board has to be mediated. GPs feel that they get consumer feedback from their day to day work. [The] Board has recently identified that health promotion is a big aspect of our work and that consumers and the community can help to give direction to that.
>
> Staff [perspective]: [The] Board [is] still uncomfortable with consumer representation - particularly at [the] board level. [Staff] have a sense that consumer and community

> participation is a desirable outcome but have no sense of how that outcome should be achieved. [There is] difficulty in finding consumer participation in our division. In this sense there are a lot of barriers to overcome to get consumer representation, [however there is an] understanding that DHAC wants divisions to engage consumers [and] that we will have to do something in the near future".

In commenting on their Board's consideration of direct representation by consumers at the policy and decision-making level, another division commented that:

> "…there are some fundamental factors militating against the use of this kind of model…
>
> The first issue is that of privacy and confidentiality and conversely, the risk of jeopardising it. GPs are obliged by law to maintain strict standards of confidentiality regarding patients. Board members have concerns that members of the public may not be as cognisant nor as scrupulous as professionals to maintain those standards… Divisional programs target a variety of conditions including HIV/AIDS, drug and alcohol addiction, genetic and family disorders, and mental illness. Disclosure of private information on these could have devastating effects on members of a small, introverted or closely-knit community.
>
> The second issue is that of medical ethics. This issue is broader than privacy and confidentiality. While accepting that people generally make ethical distinctions on subjects with which they are familiar, the board believes it should not be assumed that members of the general public will be comfortable with specialised medical matters and the subtleties of technical debate…
>
> This division believes the optimum role for members of the local communities is through liaison and input at the program level… The key link between the division and the broader community is through multi-organisational broad health programs linking a number of community special interest groups and the establishment of programs to link these groups.. Division Staff participate in these groups at Executive and Program Officer levels. Formal membership and participation provide conduits for two-way sharing of information as well as program development".

(d) Lessons Learnt

Five divisions commented that they had learnt that consumer advisory groups had been more successful once they specifically focussed or directly involved themselves in distinct program areas, rather than if they had existed separately from programs as a generalist discussion group. For example:

> "This division established a Consumer Reference Group in 1997. An officer was employed to facilitate the group. Terms of reference were drawn up, volunteers recruited to take part, a meeting schedule was developed in relation to the board meetings. Unfortunately, as time passed, it became clear that there was no fundamental raison d'etre for this group. The division and the communities were participating in policy-defined and policy-driven activities. The majority of [the Consumer Reference Group's] members eventually believed they could better use their time by participating in different groups where their individual contributions were more specific and fundamental to the success of the organisation"

Also:

> "Prior to OBF we employed a Community Liaison Officer who established a Consumer Reference Group with project funds. Now consumers are consulted on an as needs basis rather than using the same group of individuals with A non-specific role".

There were positive comments on consumer advisory group input into specific program areas. One division commented that consumer input directly shaped their approach to Koori health issues, whilst another remarked that having consumers share experiences of domestic violence during Continuing Medical Education sessions were particularly successful in defining the issues for GPs.

(e) Future Plans

Divisions' future plans for the involvement of consumers and the community in the next triennium were diverse, however there were five recurring themes:

- 22% of divisions surveyed said they would like to be involved in, or would like to strengthen their ties with the PCP consumer input process;
- 22% said they would like to increase the input of consumer or community representatives within program-specific working/reference groups, or to have them attend divisional program meetings;
- 9% said they were planning a trial of the effectiveness of consumer input to date;
- 9% said they were planning to create a feedback link from consumer focus groups to GPs within their divisional catchment; and
- 9% said they would seek to identify key consumer advocates from within their local community in an attempt to refine the membership of their reference groups (eg: one division wants to have input from a local consumer with ethnic background to better represent the composition of their population demographics).

Plans to formalise community/consumer engagement were reflected in comments such as:

> "We have a long history in the Koori area including effective consultation. This has been a lengthy process of trial and error. We have done little in consulting the community in a formal sense. Though we work closely with a range of representative organisations, we are only just beginning to establish a consumer consultation structure".

However, other divisions were less enthusiastic about formalising a CAG process:

> "Don't think that we would have a CAG - it wouldn't benefit the divisions in any great shape or form. We are looking at small populations across the division and I don't think we could be truly representative of an advisory group. And the expense involved would be counterproductive".

Other division plans included

- developing a consumer reference centre;
- seeking consumer input into Aboriginal health promotion activities;
- consumer marketing of EPC items;
- working with GPDV to refine the division's long term plans in regard to consumer input;
- involving consumers in program evaluation;
- developing patient satisfaction surveys in regard to the quality of GP services provided; and
- having consumers help set the agenda for CME sessions.

DISCUSSION

The 2001 GPDV audit of divisions' engagement with their communities provides the most rounded picture available of the breadth of divisions' community connectedness. The picture is two way, capturing the "reach" of divisions into the broader primary health systems as well as the extent and nature of inputs divisions attract into their own work. Some of the findings of the audit include:

- A markedly higher reporting by Victorian divisions of the convening of Consumer or Community Advisory Groups than is average for divisions nationally. Among the audit respondents 74 % of divisions indicated that they had such a group. From a scan of division annual reports and newsletters from divisions which did not respond to the survey GPDV is aware of other divisions which have also convened such groups. When this number are included, it appears that 73% of all Victorian divisions have or have had such groups compared with the national rate in 2001 of 37%. (source: Practices, Partnerships and Population Health: report on the 2000-2001 Annual Survey of Divisions of General Practice. PHCRIS. 2002)

- Victorian divisions responding provided an annual budget for the Consumer Advisory Group and remuneration for consumer representatives with greater frequency (76%) than the national average for divisions (68%) . (Ibid)

- A significant commitment of GP and CEO time made by divisions to engagement with municipal health planning, primary care partnership development and primary mental health care team development. Traditionally divisions have made program officer time available for these linkages and continue to do so. However the additional commitment of senior level resources reinforces the seriousness with which divisions are seeking to actively bring about change in the way other services link with General Practice.

- Not only are senior staff and GP representatives undertaking this work but divisions as organisations have achieved substantial representation on Boards of Management and program and service advisory groups of other agencies and bodies. This suggests that the ways in which divisions engage with other stakeholders are multi-layered and complex.

- The results of this audit will be disseminated among divisions and other stakeholders. GPDV will liaise closely with the National Resource Centre for Consumer Participation in Health to encourage further exploration and description of models of community and consumer engagement which can be demonstrated to be sustainable and effective for divisions of general practice.

GPDV wishes to acknowledge the advice and assistance of George Panageotou, Workforce Data Manager at RWAV in the development of a database for analysis of audit results.

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