MAKING THE INVISIBLE VISIBLE

A REPORT INTO THE PARTNERSHIP APPROACH OF SEVEN RURAL & REGIONAL PRIMARY CARE PARTNERSHIPS IN VICTORIA

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CO IMPACT

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We wish to acknowledge the generous and open participation of the 79 PCP Board members and staff in this review. We greatly appreciated the privilege of recording and sharing your stories and hope this report has done justice to your experiences, wisdom and commitment to your work. Any errors of fact are fully ours.

PCP Board Member: 'Whatever the government is going to do, don't take it (PCP) away.'

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Images courtesy Lyn Andrews: Cover, p2, p10, p11, p25.

EXECUTIVE SUMMARY

Victoria's Primary Care Partnership (PCP) strategy, launched by the Department of Human Services[1] in 2000, brings together local government and health and social services who, in partnership, utilise a place-based approach to identify local health and wellbeing issues and together develop solutions.

The aim of the review was to advocate rural PCP governance groups' (Boards') vision of a future partnership model that will support a place-based approach to deliver Victorian health priorities.

A geographical cluster of rural PCPs were selected, and the Loddon Mallee and Grampian PCPs were invited to participate. These seven PCPs collectively cover twenty local government areas (LGAs) and over a third of Victoria land area (Figure 1).

The focus of the review was on the role, structure, and effectiveness of PCPs and in particular the PCP partnership model. Data was collected via a series of closed discussion groups held with each PCP Board. Discussion groups were used in order to gain a better and deeper understanding of PCPs through exchanging a range of diverse views. Discussion groups with PCP staff were conducted separately in order to determine consistencies and/or divergence of views and experiences between staff and Board.

There were 50 PCP partner members and 29 PCP staff involved in the consultation. The partner members represented health services (46%), local government (20%) and other community services (Figure 2). The PCP members that participated predominantly held a CEO, Director or General Manager (72%) role within their organisation.

The review recognised the diversity in PCPs in their place-based response to different health and well being needs of their regional or rural communities, the breadth of their catchment in terms of LGAs, governance and the auspicing arrangements that support their work. However, very significantly, there were many commonalities that emerged across the seven rural and regional PCPs that participated.

The PCP members recognised that the whole of the partnership work is greater than the sum of individual agencies. They highly valued many aspects of the partnerships including:

- the strong rural and regional lens brought to the partnership work in their area
- the place-based expertise and approach within the PCP that leads to authentic change and enhanced equity for local communities
- the important work of PCPs in working and building linkages across community, health, local government, education and welfare sectors
- the invisible work of the partnership: nurturing, enabling, brokering and supporting partnerships
- integrated planning, shared expertise and innovation across partners, enabling partner organisations to build scale and reach
- provision and sharing of knowledge, information, data and resources
- PCP staff's expertise in supporting the partnership, their depth of local knowledge and their advocacy at a regional and statewide level.
- the capacity building aspect of the PCP work that is delivered locally according to local needs and providing local networking opportunities.

There remains challenges within the PCP platform that includes:

- the lack of clarity of the position, identity and role of PCPs in a continually changing landscape of health reform and strategy
- misalignment of PCP, Primary Health Networks, state government and organisational service boundaries
- partner organisation are in competition for service funding, which effects transparency and trust
- multiple regional partnership platforms leading to partnership fatigue
- lack of resources to support organisations to participate and contribute to the partnership work
- essential partners missing from the partnership and impacting the collaborative work
- lack of visibility of the attribution and contribution of PCP member organisations.

RECOMMENDATIONS:

There are a number of recommendations that have emerged from this review that would strengthen and embed the work of PCPs. These particularly focus on the PCP profile and role and more explicitly articulating and valuing the 'invisible' role of the PCP as partnership brokers. Based on the findings of this report, we encourage you to consider the following recommendations when reviewing the PCP platform:

1. PCPs should be regarded as the key partnership platform for health and cross sector agencies to address place-based health responses within their catchment.
2. A clear endorsement be made by Victorian Government affirming their support of the PCP platform and clarifying the roles and responsibilities of DHHS (Regional and Central Office) with particular reference to PCPs. Actions to be taken to improve DHHS understanding of and engagement with PCPs.
3. A PCP model needs to acknowledge, accommodate and be adaptable to the different and specific contexts of rural, regional and metropolitan catchments.
4. The PCP governance structure should be determined locally in order to achieve the appropriate place-based response for the catchment. This may include expanding the partnership to include more cross-sector partners, reducing Board numbers and/or introducing a tiered governance structure to ensure effective decision making.
5. DHHS consider additional funding/resources to support the PCP partners to participate in partnership work and incentives to bring disengaged or new partners to the table.
6. PCP catchments should remain small enough to achieve a depth of understanding of the local areas and provide local responses that meet the needs of the community and continue to be adaptive and flexible.
7. Explore a more place-based approach to funding models to reduce interagency competition and align resources with the needs of the community. PCPs Partners and EOs should be engaged in co-designing the appropriate structure for such a model.
8. Recognise and support the development of partnership broker skills as a requirement for PCP staff and Executive Board members to build, strengthen and sustain the partnerships.
9. Improve resourcing for the VicPCP platform to advocate the role of the PCPs within broader statewide networks and structures, including newly introduced platforms and partnerships. This would also strengthen the value, role and identity of PCPs through better communication with DHHS and support improved DHHS understanding of the PCP work.
10. PCPs and PHNs to proactively and collaboratively identify and act upon mechanisms to support closer interaction and engagement. This would focus on mutually agreeing respective and complementary roles and contributions to shared outcomes.
11. That a Monitoring, Evaluation and Learning Framework (MELF) be developed for the PCP model that is appropriate to and focused on the partnership process role of PCPs. The MELF should include monitoring and evaluation tools and reporting metrics to demonstrate PCP partnership process and value. It is also important to identify an approach to acknowledge the contribution of different partners and roles, as well as measure and report health outcomes.

1 Now known as the Department of Health and Human Services

1 / INTRODUCTION

1.1 WHAT ARE PRIMARY CARE PARTNERSHIPS?

Victoria's Primary Care Partnership (PCP) strategy, launched by the Department of Health and Human Services (DHHS) in 2000, brings together local government and health and social services who, in partnership, utilise a place-based approach to identify local health and wellbeing issues and together develop solutions.

The PCPs work with their members within a voluntary alliance to improve access, service integration, primary prevention and health promotion. PCPs support local organisations to navigate the ever-changing health and social service landscape, while retaining high quality, safe, person-centred and evidence-based services, which meet the needs of their local community.

Victoria's 28 primary care partnerships (PCPs) cover metropolitan, regional and rural areas throughout the state, with 19 rural/regional and nine metropolitan PCPs. They involve over 850 organisations, including hospitals, community health services, Primary Health Networks (PHN), local governments, family violence services, mental health services, drug treatment services and disability services [1].

1.2 THE AIM OF THE REVIEW

The aim of the review is to advocate rural PCP governance groups' vision of a future partnership model that will support a place-based approach to deliver Victorian health priorities.

In 2017, DHHS indicated that there was to be a change in the PCP platform. A number of factors and approaches were being considered for this change – the strength of the collaborative approach in addressing complex health and social issues; a range of new and emerging partnership models and platforms at state and commonwealth levels[2] and the potential to consolidate platforms; the increased competition for funding as organisations in partnership compete for government tenders; and the need to maximise effort and resources more efficiently.

The review of government documents (Annexe 2) suggests a strong interest from government on partnership and place-based models that support the delivery of population health and well-being initiatives.

In consideration of this complex array of factors, a group of rural PCPs, with the support of the VicPCP Leadership Group, identified an opportunity to articulate the value of local partnerships for their organisations and communities to contribute to the Department's review of PCPs.

1.3 WHO WAS INVOLVED?

A geographical cluster of rural PCPs were selected, and the Loddon Mallee and Grampian PCPs were invited to participate. Of the eight PCP invited, seven rural PCPs chose to participate – Central Victoria, Bendigo Loddon, Wimmera, Southern Mallee, Campaspe, Grampians Pyrenees and Central Highlands.

These seven PCPs collectively cover twenty local government areas (LGAs) and over a third of Victoria land area (figure 1).

1 https://www2.health.vic.gov.au/primary-and-community-health/primary-care/primary-care-partnerships

2 For example, Support and Safety Hubs, Metro-Regional Partnerships, Primary Health Networks (PHN), Child and Youth Area Partnerships as well as PCPs.

Figure 1. Catchment of participating PCPs

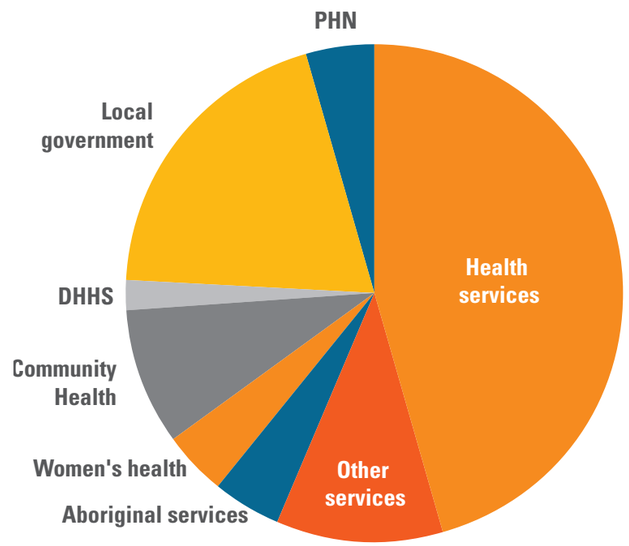
There were 50 PCP partner members and 29 PCP staff involved in the consultation. The partner members represented health services (46%), local government (20%) and other community services (Figure 2). The PCP members that participated predominantly held a CEO, Director or General manager (71%) role within their organisation.

'The primary focus of the review was to interrogate the experiences of PCP Boards as represented by the governance groups[3]. The staff of each of these PCPs was separately interviewed to test the findings of Board discussions from a staff perspective.

For a complete list of participants, their organisation and their roles refer to Annexe 1.

3 PCP Governance groups may be referred to as Boards, Management Group, Executive Committee

Figure 2. Participating PCP Board members' organisation type



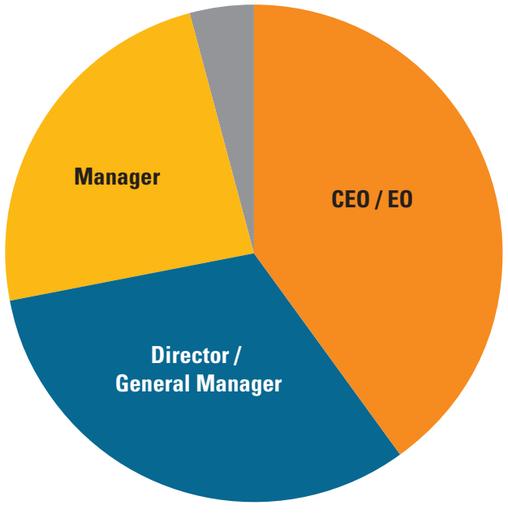


Figure 3. Participating PCP Board members: Level of seniority within their organisation

1.4 REPORT STRUCTURE

This research was not aiming to prove or disprove a hypothesis. Rather it was collecting qualitative evidence to demonstrate the value (or otherwise) of a range of rural and regional PCPs in order to tell a common story, if it existed. It is important to the researchers that the evidence speaks for itself and the voice of the participants remains true in recognition of them sharing their experiences, perspectives and visions. Therefore, the report is structured to present the researchers' analysis of the data as the issues and themes emerged, rather than according to a predetermined reporting structure or template.

2/ APPROACH AND METHODOLOGY

The review was conducted by independent consultancy, Co-Impact Consulting. It was designed and conducted by their lead consultant and co-founder, Rhonda Chapman with support from associate researcher, Carolyn Neilson and in consultation with the commissioning PCP Executive Officer.

It was important to the commissioning PCP EO that Co-Impact conducted the research completely independently of PCP staff involvement in order to ensure that any vested interests in the continuation of PCPs did not influence the outcomes. The review was designed to provide assurances of confidentiality to all participants and complete independence for the analysis and reporting.

2.1 METHODOLOGY

The focus of the review was on the role, structure, and effectiveness of PCPs and in particular the PCP partnership model. The review was designed using an adaptation of an evaluation method known as outcome harvesting. Outcome harvesting collects ('harvests') evidence of what has changed ('outcomes') and then, working backwards, determines whether and how an intervention has contributed to these changes[4].

Outcome harvesting enabled the researchers to gather qualitative evidence from PCP partners about their perceptions and experience of PCPs over time, and what has been achieved or changed as a result of the partnership models in particular. The research was designed to understand whether and how PCPs have contributed to activities and improved health outcomes and where possible, identify the causal links between PCP roles, structures and approaches with these outcomes. To achieve the aim of the review, it focused on the PCPs themselves, not the activities or related health outcomes.

The review was also informed by social theories of interpretive analysis for qualitative research[5]. This analysis was most appropriate for this research because it enabled an emphasis on understanding the PCP in their own right (rather than from some outside perspective or confirming a hypothesis); using open, exploratory research questions and drawing on unlimited, emergent description options vs. predetermined choices or rating scales.

A rapid desktop review of policies related to PCPs was undertaken prior to the consultations to provide context. The documents are listed in Annex 2.

2.2 DATA COLLECTION

It was important that the data (people's experiences, opinions, perceptions, observations) was collected in a manner that both respected confidentialities, enabled rigour and tested validity. There were also practical considerations – there was no time to meet with all participating PCP Board members individually and the time available for group meetings needed to realistically acknowledge the busy schedules of partners/Board members.

Data was collected via a series of closed discussion groups[6] held with each PCP Board. Discussion groups were used in order to gain a

4. Ann Murray Brown Blog provides an accessible explanation of Outcome Harvesting. Outcome mapping and Utilization-Focused Evaluation (UFE) are described here https://www.betterevaluation.org/

5. http://nideffer.net/classes/GCT_RPI_S14/readings/interpretive.pdf

6. Definition: Group discussion may be defined as a form of systematic and purposeful oral process characterized by the formal and structured exchange of views on a particular topic, issue, problem or situation for developing information and understanding essential for decision making or problem solving. http://wikieducator.org/Group_Discussion_Technique

better and deeper understanding of PCPs through exchanging a range of diverse views. Discussion groups with PCP staff were also conducted in order to determine consistencies and/or divergence of views and experiences between staff and Board. The discussion groups were facilitated by the lead researcher.

A consistent process and structure was used for every discussion group to ensure the integrity of data collection. All participating PCPs were sent a briefing note in advance of the discussion group that explained the process and the four questions they would be responding to during the discussion group (see Annex 3). Each discussion group was conducted in two distinct parts – individual reflection followed by group discussion

2.3 DATA ANALYSIS

A synthesis of the notes and audio recordings from each discussion group was shared with the participants from that group via email. The researchers took great care to ensure confidentiality of the notes, emailing only those participants who attended the discussion. PCP Board did not see staff notes nor vice versa[7]. Participants were invited to correct, comment or add any comments. Most took the opportunity to validate the notes as correct and many shared comments of appreciation:

> *'It was a nice opportunity to reflect, bring everyone together, a simple very effective, participatory process.'*

The six discussion groups were conducted over a period of eight weeks from mid-October to mid-December 2018. The outcomes of each discussion group were progressively analysed throughout this period, with common themes and issues as well as divergent ideas and issues iteratively identified and analysed as the review progressed.

It is important to note that the primary analysis focused on the PCP Board discussion groups as the critical stakeholder group. This is not to suggest that the views, experiences and perspectives of PCP Staff are not important for this review. However, the researchers needed to ensure that any interests of PCP Staff in preserving their roles in the current model did not influence the findings. The findings presented in this report present the primary analysis of the PCP Board discussion groups. The findings from the staff discussion groups are included secondarily to indicate when they confirm or diverge from the Board view.

2.4 REVIEW LIMITATIONS

The limitations of the review and how they were addressed include:

Skill and time, as well as timeliness, are required to identify and formulate high-quality outcome descriptions. The timeliness was determined by the DHHS review. The researchers conducting the review were selected because of their experience in conducting participatory social research; specialist skills in partnerships and experience working with PCPs.

It is acknowledged that the consultation only involved those that were at the table and did not include the PCP partners that were absent. This was addressed by providing an opportunity for all PCP members to send their views electronically in response to the briefing paper (Annexe 3). The researchers acknowledge that the voices of PCP associates and program participants are not included in this research.

As with all complex social research, the scope of the review was limited by the funding and time available. The review was designed in order to maximise participation and voice within these limitations without compromising rigour and validity.

The voices captured in this report are representing rural and regional PCPs only. These findings cannot be transferable to the opinions or functioning of the metropolitan PCPs.

7. While staff and Board did not receive each other's notes, some did say they would share them together and use these as the basis of an ongoing reflective discussion.

3/ FINDINGS & RECOMMENDATIONS

3.1 SUMMARY – KEY HEADINGS, CROSS CUTTING THEMES AND MIND MAP

The review recognised the diversity in PCPs in their place-based response to different health and well being needs of their regional or rural communities, the breadth of their catchment in terms of LGAs, their partner engagement and governance and the auspicing arrangements that support their work. However, very significantly, there were many commonalities that emerged across the seven rural and regional PCPs that participated. These have been presented below, organised under five broad headings that reflect the common themes that emerged throughout the research analysis:

- Rural PCPs as a platform
- PCP Partnership Process
- Leadership and Strategy
- Place-based Responses
- Knowledge Brokering and Information Sharing

3.1.1 Cross Cutting Themes

As well as these general headings, three clear cross-cutting themes were also identified as having some influence or bearing across the findings, and/or as being relevant to many aspects of the PCPs involved in the review.

THE VALUE ADD OF PCP - THE WHOLE IS GREATER THAN THE SUM OF THE PARTS

There was a common reflection across all PCPs that the whole of the partnership work is greater than the sum of individual agencies. PCP partners recognised the value add derived from the breadth of their partnership work in contributing to positive health outcomes. They particularly recognised it in the integrated planning, shared expertise and innovation across partners, and in the way that it enables partner organisations to build scale and reach. The contribution of their engagement in partnerships is enhanced by partnership maturity – by which people meant the length, durability and quality of partner relationships and the ability to have open, robust and honest conversations.

'[There is] value add in pathways work, over last twenty years, we are now in a new chapter where there is a maturity in partnerships and collaboration.'

'[We] seem to have a bigger footprint than our own catchment'

BUILDING CONNECTIONS ACROSS SECTORS

Partners acknowledged the important work of PCPs in working and building linkages across community, health, local government, education, and welfare sectors. The role of PCPs and the resultant breaking down of inter-organisational silos is seen as significant for positive health outcomes and regarded as a strength of the PCPs by all partners.

'[The PCP] brings together key stakeholders across Health, Community Health, Councils, ACCHOs and special interest groups and does it well.'

'[PCPs working across sectors] breaks down silos, and provides the glue - connecting organisations and enable partners to meet DHS priorities

Staff also indicated the importance of enabling cross-sector collaboration.

'Cross sectoral approach is the biggest strength of the partnership because it brings the valuable work of each organisation to the table and keeps them informed of what the others are doing which doesn't always happen.'

RURAL AND REGIONAL CONTEXT

Rural people have poorer health[81], which is compounded by decreasing or loss of local services, reduced housing options, less secure and costlier access to fresh food and water. People in rural areas are also more susceptible to the damaging effects of climate change (drought, flood, bushfires) that affect not only the agricultural community but also the townships that service them.

Attracting experienced and a highly skilled health workforce continues to be a challenge for rural areas, creating gaps in local services. Access to services is further compounded due to the tyranny of distance to access specialised services, with some areas also experiencing limited public and private transport options.

Partners reiterated the challenges of the geography of their rural and regional context, particularly those with large PCP catchments with multiple LGAs. Not all PCP boundaries align with local government, PHN or DHHS divisional area boundaries. This also presents an issue for partner organisations which service large geographical areas that cross over multiple boundaries in relationship to stakeholder partners and funding bodies.

Additional to partner reflection, staff also noted the impact of large service providers residing outside of rural and regional catchments that are not at the table and funding models that did not reflect or consider rural and regional realities.

PCP partners universally appreciated the strong rural and regional lens brought to the partnership work in their area.

'[We] appreciate the need for the rural and regional voice around the table everywhere and the PCP are doing that for us'

3.1.2 Inter-linkages Between Themes

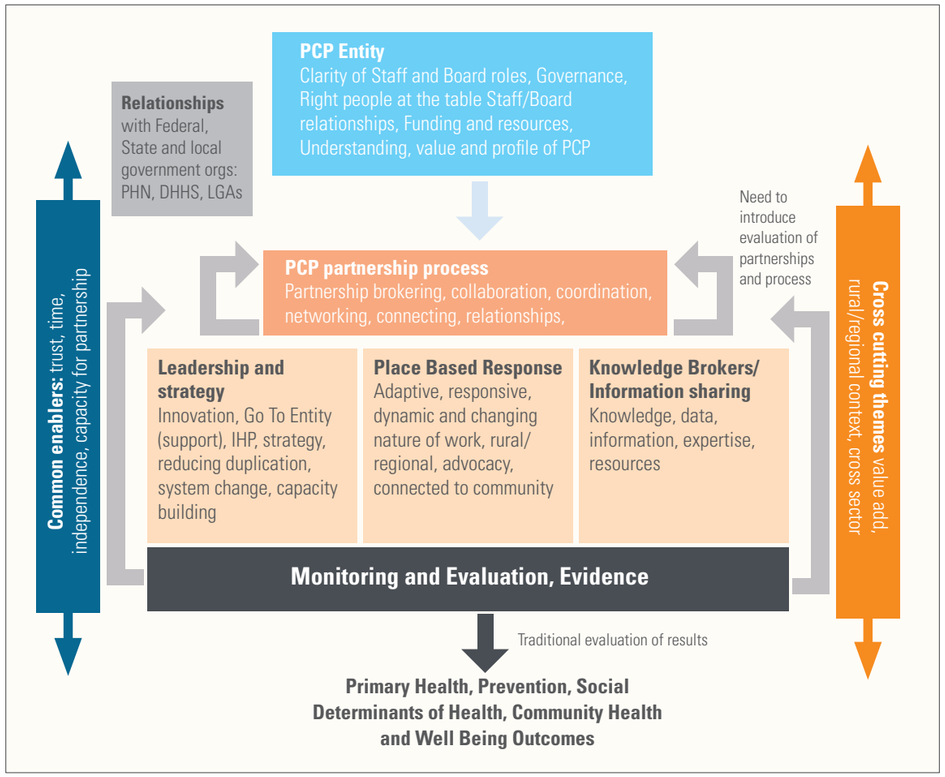
While we have presented the findings in distinctive sections, the inter-relationships between these themes are as critical to understanding the impact and contribution of PCPs as the themes themselves. For example, the way a PCP operates as a platform influences and creates the enabling factors that influence the effectiveness of the way a PCP brokers and holds partnership processes. This in turn influences the quality of relationships based on trust and openness that contributes to leadership, strategy, their strength of place-based responses and their role as knowledge brokers.

We have mapped the inter-linkages of these

8. AIHW, 2010. Australia's health 2010, Australia's health series no.12, cat. no. AUS 122, Canberra: AIHW. Available at: http://www.aihw.gov.au/publication-detail/?id=6442468376 [Accessed 9 September 2014].

themes in figure 4 below – not as a definitive analysis of all the relationships and connections but as a way to help readers navigate the different themes and issues that emerged in the review. A selection of case studies has been included to allow the stories as told by participants to illustrate the inherent complexity and inter-linkages of the role and practice of the PCP.

Figure 4: PCP Inter-linkages



3.2 PCPS AS A PLATFORM

Most partners recognised the PCP platform in terms of structures, governance, and relationships with other state and federal organisations (DHHS, PHN, LGAs, VicPCP).

Many partners referred to the PCP partnership platform as 'a long term constant that synergises effort and shares skills, delivers projects, with a shared vision; a platform that has a common purpose, joint responsibility, common objectives and 'helping to make sense of our worlds'.

'[It is] an organisational structure that is known … across the local government areas and all state government departments - don't reinvent the wheel.'

Having clarity of roles of Board and staff, staff/ Board relationships, ensuring the right people were around the table, understanding who PCPs are and their role in relation to the community, DHHS and partner organisations were all recognized as influencing the function of PCP partnership platform.

Commonly recognized barriers to the functioning of this platform were the lack of sustainable funding and resources for PCP partner organisations, lack of clarity of the relationship between PCPs and PHNs and the perceived lack of commitment of DHHS to the PCP platform and their lack of support for the VicPCP platform.

3.2.1 PCP Identity and Profile

All partners linked the identity of the PCP platform to primary health, social determinants of health, prevention, community health and well being, outcomes achieved through system change and a local/regional focus on strategic priorities and emerging population/community sector needs.

Outcomes were more positive when the PCP was well understood and recognised by partners (not just those represented on the Board), and in some (but not all cases) the community. Partners acknowledged that partnership work is complex and dynamic and that sometimes there is confusion as to who or what is the PCP. This may be related to an inability to demonstrate the value of the generally invisible work conducted by PCPs (see Section 3.3 – PCP Partnership Process).

A small number of partners noted that the focus on reporting health outcomes and/or a lack of clarity of roles and contributions in the PCP sometimes created the impression that the PCP staff was the implementer and responsible for outcomes rather than as a result of the work of one or more partners. However, Partners noted that when PCP staff did implement projects, this more tangible work of the PCP was done well.

3.2.2 PCP Structure/Roles

Partners identified the essential complementarity of the PCP Board and staff in the partnership and the importance of clarity, leadership and competencies in managing their respective roles. Having the 'right people' around the table was identified as an important factor in the effective functioning of the PCP. Some partners believed that they had the right people on the Board, others felt they should broaden their partnership base to reflect their community's emerging needs.

For the majority of partners, there was a strong sense that the PCP is the partnership; the executive officer and staff support the work of the partnership and that demonstrates the maturity of the partnership. There is a real sense of each partner agency understanding their role in the PCP and the collective benefit that PCP provides their agency.

Governance structures varied between the participating PCPs. Some had all the key stakeholders represented on the Board, whereas others had a tiered approach to ensure decision making remained manageable and effective. There were some PCPs that had a separate executive board to provide support for the PCP EO and staff.

Partners felt that the governance structure of PCPs generally worked well. Most PCPs felt that the structure of the PCP and roles of staff and Board were clear and well enacted upon. Relationships between staff and Board in terms of recognising their respective skills, intentions and contributions were generally regarded as very good (see also Section 3.3 – PCP Partnership Process).

'Staff are the backbone/project officers/ partnership brokers while boards give strategic direction and governance and can operationalise projects.'

All partners recognised the quality of the PCP staff who they saw as highly skilled, committed, flexible and who work well together.

Partners noted the importance of strong relationships between health/social services and local government (especially for Integrated Health Promotion) but engagement with local government was mixed. This ranged from highly constructive and positive, to frustrated and disengaged. One partner expressed frustration that the 'shire is not in the room as a partner' while others acknowledged a strong relationship with local government where the 'PCP recognised the role of the local government really well.'

3.2.3 VICTORIAN PCP STRUCTURE

Partners described the collaboration between PCPs at a regional level as working well. The role of a Victorian PCP director/Statewide PCP structure provided 'a state-wide structure where we have an opportunity to come together and share lessons' and was seen as important to PCP functionality. At the same time, some partners spoke of their concerns at the weakening of the VicPCP group.

'There has been a degradation of the governance, relevance, ability of the Statewide Group since there was uncertainty about the future and people have left.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

All partners recognised that the PCP has a role in being a conduit to DHHS as the funding body, noting that this role is multi-faceted. The PCP role includes building relationships between DHHS, partners and other organisations; providing a reality check for DHHS ideas; being a mechanism for DHHS to drive changes in primary care initiatives; and translating DHHS information for their stakeholders, especially for more rural and marginal community and health organisations.

The majority of partners stated that the constant flux and restructuring of DHHS had led to detrimental impacts on their understanding, engagement and communications with PCPs.

'DHHS staff have moved on, there is a revolving door, history has been lost, initial objectives have really changed and so very few people [in DHHS] have a sense of the history, no corporate memory or understanding of the PCPs'

Partners identified a number of DHHS related barriers to their PCP practice:

Eroded PCP-DHHS Relationships: A lack of DHHS understanding of PCPs, particularly the regional/rural context in which they operate, coupled with weak DHHS relationships and a general disengagement from PCPs. 'Central office DHHS has a very metro centric view of the world.' 'There is no-one at DHHS policy level who really understands or is dedicated to speaking on behalf of PCP. The previous strong relationships with DHHS aren't there anymore'.

DHHS Direction: There is inadequate and inappropriate DHHS communications, support, decision-making and strategic direction. 'The lack of direction from DHHS and shifting goal posts means we are not clear where we are going.' There is a lack of alignment between DHHS and PCP priorities.

Uncertain Future: The protracted uncertainty regarding the future of PCPs, compounded by the emergence of new partnership structures during this time, has negatively impacted on engagement, staff continuity and security, and long term strategic planning.

'There is lots of uncertainty.' '[The] uncertainty of the future contract has impacted on strategic planning and on staff continuity.'

'[We want] a clear endorsement by Victorian Government that the PCP structure/platform will continue and that they will make better use of it thus increasing commitment and benefit of local organisations.'

PRIMARY HEALTH NETWORKS (PHN)

Partners generally acknowledged that PHN and PCP roles are different. PHNs are federally funded and more focused on contracting or commissioning work rather than directly implementing services/initiatives.

Partner responses on how well PCPs interact with PHNs varied – for this to be strengthened it is recommended that PCPs and PHNs proactively and collaboratively identify mechanisms to support closer interaction and engagement. This would focus on mutually agreeing respective and complementary roles and contributions to shared outcomes.

3.2.4 PCP Resources and Funding Models

All partners recognised that there was inadequate, sustainable funding and resources for the PCP partners to effectively engage in the long term and complex partnership work. Sustainable funding is also essential to resource the recruitment, retention and training of skilled staff with appropriate partnering skills. The lack of sustainable funding is compounded by the current landscape of funding competition. Increased competition may erode transparency and trust, adversely effecting partnerships. Many also spoke of the uncertainty regarding DHHS continued funding of the PCP platform.

'Federal and State funding creates animosity and competition between partners. Why should we have to compete to provide health services? This just doesn't align with what we do – such a difficult job for PCP trying to hold that space, just nuts.'

'Participation in partnerships is not recognised or funded to the degree required. Shared services and engagement takes time.'

All partners recognised that PCPs are efficient and effective in their practice despite the small amount of funding and resources. Their work is valued and they are well reputed. 'They do a lot of good with the little money they get – they use it well, a no frills organisation, no fluff.'

BOARD CASE STUDY

"The agencies are well supported by the PCP staff and we use their resources and expertise. They are very efficient and effective. From an Alliance point of view – the tele-health project was sitting there, just bubbling not doing anything – we couldn't get it up and running. A PCP staff member then took responsibility for it. She connected and engaged with and informed the relevant stakeholders of the project enabling and coordinating the stakeholders' involvement. It then got traction and she was able to support it in an ongoing way.

You know we (one agency) pay for that service and we're happy to do that, but at the end of the day we couldn't get it up and running, we didn't have the expertise. Then with the assistance of one PCP staff member, all of a sudden tele-health got a massive amount of traction and since then it has been replicated by everyone else under the sun. It is now rolling out across our medical clinics and staff. It is really going well."

3.3 PCP PARTNERSHIP PROCESS

All partners readily identified the invisible, qualitative, complex, and sometimes challenging work of the PCPs, particularly the partnership brokering that builds, strengthens and sustains the partnerships. Partners described important relationships that can be local or regional and involve a diversity of players (community, health, local government, welfare, funders, department and others) in a dynamic setting. It was also recognised that mutual benefit and equity are important aspects of functioning partnerships.

'A genuine partnership has mutual benefit.'

The PCP platform provides the foundation for partnership work, which includes partnership brokering, offering a backbone or support function, building and maintaining relationships and demonstrating the mutual benefit of partnering. Partners identified a range of important enablers for this partnership process - trust, time, neutrality, independence, safety, capacity for partnership and skills of the staff and Board.

3.3.1 Partnership Brokering

Generally partners felt that the partnerships were working well. They stated that PCP brokering involves bringing new, old and diverse organisations together and that PCPs are champions of collaboration, connecting and networking. PCPs also play a vital coordinating role locally and regionally, sometimes with other regional partnerships and sometimes between PCPs, with one partner stating that PCP 'connects the dots between us'.

'PCP is networking amongst the partners, other organisations and community but also recognising that it is more than networking – it is about high level decision making that occurs at the executive level. [It's] about building on the strength of relationships that have been purposely built around strategic alignment, decision making and enabling.'

A minority of Board members felt that when the complexity of partnership factors were not synchronizing well, the partnership felt tired and directionless. In a few cases, partners felt that PCP staff was too operational, however all PCP Boards felt that the partnerships and outcomes had improved over the lifetime of PCPs.

'We're better at partnerships now, so much better than we were 10 years ago.'

'There is high quality partnership brokering, not service delivery.'

'PCP is a great opportunity and we are at a tipping point with an opportunity for strategic partnerships. We are making a difference, we're shifting the dial, working together to change what needs to be changed.'

All partners agreed that the PCP brokering role was more nuanced and complex than project management and coordination and that the partnership brokering role was highly valued and critical, yet at times invisible. It was noted that while some PCP staff and Board have attended formal partnership brokering training, it was agreed that this should be more readily available, particularly for staff given the acknowledged role played by PCPs and the inherent complexity of effectively working in partnership.

3.3.2 Good Quality Relationships

All partners concurred that crucial to this brokering role is the building and sustaining of long term, trusted relationships that really add value to outcomes.

> *'PCP relationships are key – they hold really good relationships between state, local government, hospitals and primary care which are tricky areas to negotiate and hold strong relationships.'*

> *'[These relationships] enable collegiality, especially in a rural area where these quality relationships create empathy between providers. This goes a long way to opening doors and smoothing delivery of services, particularly relevant at a local level where localised delivery of health is more emerging than planned (for example, in response to drought or flood, or for mental health). These relationships are more of the invisible work of the PCP that yields value and outcomes - because of those relationships it became easy to respond and to use the PCP platform.'*

Many partners stated that it is the quality of the relationships working together that has impact beyond formal strategic plans and objectives. '[Our PCPs have] strategic plans and motherhood statements but it is the being together that works and often the peripheral conversations and actions that have the impact.'

Partners also stated that an important value add was the strategic, innovative and 'outside the square' thinking that working in trusted relationships enabled. Partners discussed examples and experiences where agencies that traditionally would not have done so, have worked together in innovative partnerships and that the PCP plays a critical role in supporting that.

> *'Our sector is not part of the traditional health stream and as such, sees PCP as a bridge between the worlds of traditional health and other sectors. This brings real value and helps those of us in the traditional health sector think more holistically beyond a specific health issue, enabling us to think about underlying issues, not just thinking that this person has diabetes. That is really important.'*

All partners identified the crucial role played by PCP staff in the building of these relationships, noting that strong relationships required time and trust, and acknowledged that the stability and longevity of key staff roles enhanced this[9]. The PCP staff are trusted because they are independent, neutral, don't have an agenda, and 'they are external to our organisation but also understand us on the inside.' Being perceived as independent to the DHHS was also important to building trust.

Some partners elaborated on their sense of safety in a PCP space, where they feel they can 'seek a different point of view from someone else, discuss issues relevant to their own organisation under code of silence, seek help, and not feel the need to know all the answers.'

3.3.3 Partner Commitment and Capacity to Partner

Most partners recognised the constant and continuous work of building partnerships and the challenge presented by changes in their representative personnel in an ever-changing health and social sector. They also recognised that a lack of capacity or erratic engagement or commitment by other partner agencies to the partnership presented significant barriers to sustaining effective partnership work, 'when one partner does not value the PCP, it is difficult to make progress as a group'.

> *'We (the partners) are here, passionate, committed, diligent, there is buy-in and involvement despite being busy in our own work plans.'*

Although they expressed a commitment to the complex and dynamic work of the partnership and valued the good will and commitment of core members, they also reflected on factors that contributed to a lack of capacity to partnership work, confirming the critical importance of partnership brokering skills for staff and partners:

- A lack of organisational resources to support adequate engagement
- Partnership fatigue due to the burden of current policy and structural environment on organisations
- Organisational internal resourcing and staff turn-over issues
- Incongruent boundaries of sphere of influence of various state and federal agencies/entities

'[We] can't ignore the potential of partnership fatigue. We are aware of regional partnerships and have MOUs for new Regional and Local Area Health Partnerships as a recurrent funding stream. This presents a huge potential for fatigue especially for smaller agencies sitting around multiple partnership tables.'

'In age and disability sector we have had 75% staff turnover in our region in last 18 months. I have lost track of CEO changes and they don't stay in the catchment. This is also reflected in our executive committee that has a high turn over that requires constant induction.

'The PCP boundaries don't [always] match boundaries [organisation service areas, DHHS regional areas, local government or PHN]. How many things can we attend and add value to?'

9 One participating PCP had an average of staff tenure of ten years.

3.4 LEADERSHIP AND STRATEGY

Partners stated that the leadership of the Executive Officer (EO) role is critical to the effectiveness of the PCP. The relationships of PCP staff and Board are at their optimal when there has been stability of both; the Board recognises and supports the partnership brokering role played by the staff; and the staff and Board engage openly. This appears to be most evident when there is strong and capable leadership by the EO navigating those relationships, and when there is active engagement by the Board.

'[The] EO lives, eats, breathes partnerships and just gets that – as an inherent understanding of what PCP is meant to do in working together in collaboration, advocacy with the department, working in rural areas, how to work locally, enabling shared understanding, how to leverage relationships – also really good at pushing and setting boundaries and scope and connecting with others.'

Strong leadership leads to strong partnerships where trust, neutrality and a rural/regional lens enables PCPs to be strategic, show leadership and support innovation. This leadership and strategy enhance the capacity of PCPs to be the 'go to' for support and advice, to facilitate integrated planning (especially Integrated Health Promotion) and build local capacity of partners, organisations and community in a place-based, and often innovative, way.

All partners commented on the important leadership support and understanding provided by PCP staff for their partners and other organisations, especially for smaller or marginalized organisations. This support has become especially important in the current reform landscape, the competitive funding environment and the privatisation of the sector. This support is provided on request but also in a proactive manner.

'There has been a lot going on around primary health changes in past eighteen months with NDIS, aged care and more. The PCP staff is very aware of this and helps us make sense of it all. They are a resource of help, and always a first port of call.'

'The things that happen 'TO' us from our funding body aren't always easy and can set us up to fail – they (PCPs) see the gaps to help us succeed. They support people, community and organisations to succeed vs fail.'

3.4.1 Integrated Planning

Most partners commented on the value of the PCP providing the platform for shared planning and the leadership that provides clear, community-driven goals and helps to reduce duplication of effort and services.

'The PCP reduces duplication of effort- the PCP staff are the foundation stone to park and try an idea, be strategic, find out what is going. They are a fabulous conduit and repository for that trusted information. This reduces duplication, enhances value, enables scaling.'

'One of the strengths of the partnering leadership is planning together. Our PCP uses three metrics for our planning: 1) what is the evidence?, 2) what is the evidence which comes from the experience of the sector?, and 3) what is the voice of the community?, These are really powerful metrics and help us define how we work together, how we work towards the goals and really value adds.'

Partners recognised that the current service landscape presents a number of challenges for effective collaborative planning and limiting duplication. These include:

- nonalignment of organisational boundaries
- emerging new regional partnerships and structures
- different buckets of funding for same issues
- different organisational priorities and funding models.

Within this context, there can be duplication of planning, activities, representation and reporting. The PCP plays a key role in limiting the duplication of effort and maximising opportunities for collaboration. However, it wasn't always clear to partners where the PCPs sit within the new structures, particularly in relation to the regional partnerships.

3.5 PLACE-BASED RESPONSES

Place-based work is a person-centred, bottom-up approach used to meet the unique needs of people in a given location by working together to use the best available resources to gain local knowledge and insight. By working collaboratively with the people who live and work locally, it aims to build a picture of the system from a local perspective.

All partners recognised the importance of the PCP place-based response in achieving health outcomes and reflected on contributing factors such as their strong connection to the local community and relationship with partners that has developed over time. They value the PCP's agility in being adaptive, reflexive and responsive. These qualities allow them to respond to the changes in a dynamic sector landscape and the changing needs of the community eg drought, fires, floods.

Partners appreciated the place-based expertise and approach within the PCP that led to authentic change and enhanced equity for their local communities. This is increasingly important as the emerging competing partnership structures do not have the capacity or knowledge to meet local needs. Partners appreciated the strong advocacy role played by PCP for their rural and regional communities especially for the smaller and marginalized agencies.

> *'PCP staff know how to bring in local knowledge and players, creating place-based outcomes, created through multiple perspectives and thinking that doesn't happen otherwise.'*

> *'I am always impressed by the really strong local focus – the PCP is very good at generating a local response and creating something that actually makes a difference in our community because that is where they have so much focus – very place-based, not working with some model designed in Melbourne and dropped into the regional context.'*

> *'This has become more important as we see the regionalisation of networks through the regional health partnerships and the move to the PHN. The risk of losing our identity. The PCPs maintains the ability to meet local needs.'*

Partners reflected on the changing nature of PCP work from original service coordination and Better Access To Services (DHHS) to more of a focus on prevention and the social determinants of health. A place-based approach to the work, with access to local information and data enabled them to respond in a timely way to changing needs of their communities.

> *'Being engaged with the PCP helps me in my role in small rural organisation to look at issues such as Family Violence and Gender Equity. It provides access to the broad community interest I wouldn't get otherwise and is time well spent.'*

In response to adopting a place-based approach, many of the partners reflected on how each PCP is different and the significant difference between metro and regional/rural PCPs.

Some partners noted the tension between a place-based approach and a push towards alignment with state-wide priorities. They recognised that the different approaches across PCPs was good for local/place-based issues but perhaps led to a lack of state-wide impact, raising questions about the expectations for alignment of PCP outcomes at a state level.

BOARD CASE STUDY

"We have been able to leverage the work that the PCP staff have done internally – the PCP assisted us with a process of understanding our work, developing internal language and understanding the needs of consumers. It started with a consumer survey and analysis of the feedback that led to our understanding of our consumers' expectations. This was very pivotal work, it enabled us to identify the work to be done: what organisational expertise, infrastructure and policy documentation needed to be developed.

The PCP was around to follow up on this work and has continued to work with us on internal policy development eg regarding supervision, planning a new building, developing a Theory of Change, assisting us to respond appropriately to a sector in reform, and challenging our thinking about concepts relevant to the community health sector. This is really critical work with us.

It was really great to use and build on local expertise. We were able to access this service locally rather than employ someone expensive from Melbourne and also allowed us to have consistent local follow up through the PCP."

3.6 KNOWLEDGE BROKERING & INFORMATION SHARING

All partners identified and valued the provision and sharing of knowledge, resources, expertise, data and evaluation in building evidence.

PCPs are regarded as the 'go to' source of information as they are considered subject matter and community experts with trusted advice. PCP staff and Board are viewed as:

- A brains trust
- Knowledge bank and brokers
- A conduit for information, skills and resources
- The holders of real community and regional knowledge

Partners highly valued the quality of expertise, information, and knowledge shared by PCP staff and Board members, and that the staff provides an understanding of the complex environments we work in – the complexities, the frameworks, legislations, challenges for various sectors. This is a unique skill.

Partners stated that the sharing of experiences and knowledge 'provides a contextual framework for what you are doing in your own service and can focus on what your service needs to do based on real experience and others reality, rather than long memos, being inundated by emails, directives – knowing what works and doesn't from others' experiences. This is active shared learning … we have learnt some real gems between partners.' The PCP offers partners 'a good environment to talk about non-specific PCP issues-shared expertise enriches everything we do'

At a more practical level, partners stated that the ready sharing of knowledge and information enables them to 'get a real understanding of each other's organisations and helps to flow service delivery within our own competencies' and also valued the range of updated and clear communications maintained by the PCP staff. In particular, all partners highly valued the sharing of data, stating that it saves them hours of work.

'The data is a snap shot but [PCP staff] also spend time with us in our communities to get that more in depth understanding of what we're experiencing'

Partners highly valued the PCP staff as human resources and sources for expertise. 'PCP staff gives momentum to things that are brewing, we don't have the people, resources or expertise to get it snowballing.'

They also highly valued the capacity building aspect of the PCP work. They appreciated the breadth of capacity building available for partners, organisations and the community and that it was delivered locally according to local needs and where possible by local practitioners to sustain rural/regional lens. Often it was delivered with many organisations together to allow for cross fertilization of experiences and knowledge and building of relationships.

'I have really appreciated the professional development opportunities. For example, I have learnt far more about family violence initiatives from this group than I have from State Ministerial and DHHS briefings This is where I get my real information.'

'PCP capacity building embeds local practice, so it isn't sitting with 1-2 people but across organisations.'

3.6.1 Monitoring and Evaluation/Evidence

Partners recognised the importance of monitoring and evaluation and the PCP are active in collecting data and information to inform their work. Partners described numerous examples of how this information has been used:

- To identify and analyse trends, and informing response
- For the Annual Best Practice Forum, collaboration of evidence gathering and sharing
- For advocacy and funding submissions especially in this highly competitive environment
- Developing common Integrated health promotion measures, provides accountability

BOARD CASE STUDY

"The mental health first aid training for our community came out of drought funding – we knew our communities were suffering with the drought, it wasn't just suicide it was depression, families falling apart, just a disaster. We (PCP) did one of those workshops and decided the MHFA training needed to be rolled out. The PCP staff designed the pilot project and evaluation and the pilot was successful. We then got recurrent funding because we had built good evidence. That's the beauty, because we anecdotally knew things worked but we didn't do the research so didn't have the evidence ourselves."

BOARD CASE STUDY

"The Community Health and Wellbeing Profile, it is a great document that we can use for our own organisations but also serves the community and partnership really well. It has been really useful and we relied on that sharing of information amongst agencies that has been given willingly. It was a complex piece of work getting that information together but I can't tell you the amount of stuff I've used for multiple purposes – and often accessing information from other organisations that I wouldn't easily have had access to."

However, many partners concurred that it is hard to demonstrate the value of PCP work and make the invisible visible. In other words, being able to explicitly and articulate the value add of the qualitative partnership brokering work, collaboration, networking, connecting, facilitating and support. Understanding, assessing, evaluating and reporting this work requires a different language that requires a different approach to the traditional DHHS health metrics of reporting.

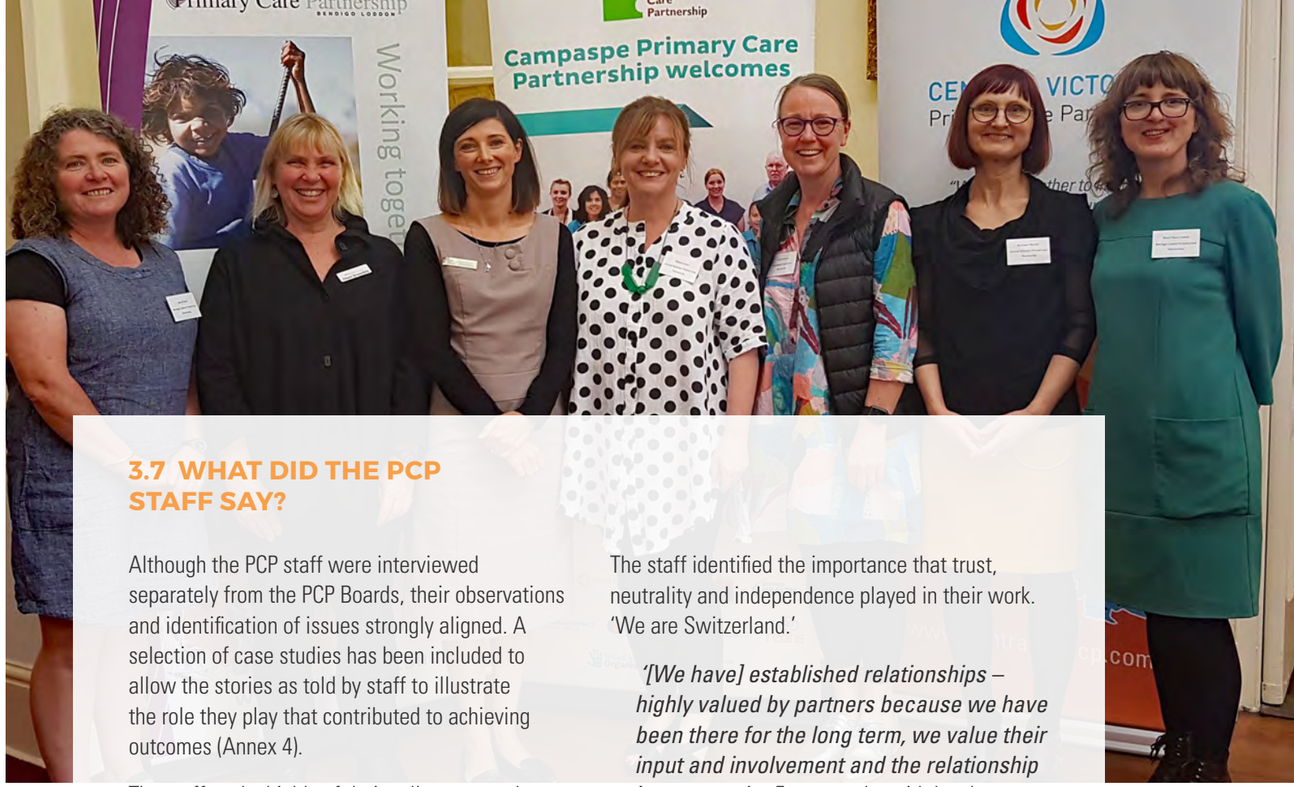
The PCP Program Logic (2013-17) does not explicitly address partnership except a reference to 'cross sector partnerships' as one of the guiding principles. Further, the Program Logic contains significant implicit assumptions about the partnership process without explicit acknowledgement of the work, time, skill or qualities (such as trust) required to effectively implement them.

Partners agreed that truly understanding the impact and value of the PCP requires a more nuanced approach to qualitative monitoring and evaluation that enables the PCPs to capture and make sense of the processes that sit behind the health outcomes that are typically measured, evaluated and reported.

'Health work doesn't have language for this brokering work.' 'Government often selects the wrong measures of success. They are not measuring the value or success in relationships or the small subtle regional approaches, like health promotion.'

'There is a need to demonstrate the value add of the invisible. It is always difficult to demonstrate or evaluate the qualitative outcomes of partnership work, we try and when we do it, it's not understood – the receivers continue to be focused on the tangible stuff.'

'PCPs are vulnerable to the political process and government electoral cycle without the opportunity to prove the value that takes a long time to demonstrate.'



3.7 WHAT DID THE PCP STAFF SAY?

Although the PCP staff were interviewed separately from the PCP Boards, their observations and identification of issues strongly aligned. A selection of case studies has been included to allow the stories as told by staff to illustrate the role they play that contributed to achieving outcomes (Annex 4).

The staff spoke highly of their colleagues and partners and appreciated the leadership they both provided.

'We work well as a team – good open communication and we have leadership, explicitly breaking down silos, inclusive culture and good mix of the right skills, technical skills, shared values and good heart.'

'The Board have demonstrated courage and leadership – we were the first PCP to focus solely on prevention, the Board took that to the department and got it approved.'

They also elaborated on the importance of clarity of staff and partner roles to enable them to be more strategic across their catchment and within the region utilizing their strengths in cross sector and inter PCP links.

'Because we don't deliver services, it gives us space to be creative and reflective and think broadly instead of constantly running',

'We have a regional picture and landscape -we are privileged to have a good catchment view that those on the front line don't have'

The staff identified the importance that trust, neutrality and independence played in their work. 'We are Switzerland.'

'[We have] established relationships – highly valued by partners because we have been there for the long term, we value their input and involvement and the relationship is trustworthy. For example, with local Aboriginal organisation, if we approach them about some work they say "we'd do anything for our PCP".'

'The partnership is the organisations and the trust in the PCP staff enables trust within the Board to support each other – ideal of partnership is when partners offer to contribute or share resources without strings because they see the opportunities. I see that in meetings and I just sing…they recognize the mutual benefit.'

PCP staff reflected on the important but challenging aspect of partnership brokering work, the respectful calling of negative aspects of the partnership; inviting and enabling honest, constructive feedback on the work of PCP staff.

'Being open and honest – being able to be clear about our role, seeking feedback, having courage to put something on the table and having a conversation that could be good or bad.'

Similar insights on the importance of the PCP place-based responses emerged from the staff findings: *'PCPs tells the stories of the community.'* Some staff described how they use innovative technology to improve access in low service areas.

Staff findings regarding relationships with local, state and federal governments were consistent with those of the partners. Experiences collaborating with PHNs ranged from frustration to positive.

Staff consultations generally confirmed the partner comments regarding relationships with DHHS though one PCP staff recognised that DHHS function could be dependent on who sat in regional office and that their current experience with DHHS was positive.

On a practical level the PCP staff highlighted the challenges of different cost recovery by employers and many referred to the challenges of the lack of commonality across PCP auspice agreements. They also confirmed the challenges of inadequate funding and resources with some noting that funding models didn't reflect the realities or complexities of the regional/rural setting and that funding was thin over a large geographic area/catchment.

4/ RECOMMENDATIONS

There are a number of recommendations that have emerged from this review that would strengthen and embed the work of PCPs. These particularly focus on the PCP profile and role and more explicitly articulating and valuing the 'invisible' role of the PCP as partnership brokers.

There is no question that partners highly value the work and role of the seven PCPs that participated in this research. However, there was acknowledgement of the lack of resources and capacity to enable partners to fully contribute to the partnership. It was noted that the absence of some partners at the table impacted on some of the collaborative work and there is a risk of partnering fatigue with new regional partnerships forming.

What was striking was the overwhelming appreciation for the 'invisible' role (nurturing, enabling, brokering and supporting partnerships) that PCP staff and Board played in enabling the effective partnerships, which were the basis of many successful initiatives and thus positive health outcomes. One of the challenges for any partnership model is to develop structures, mechanisms and processes that make the invisible visible that are adaptive to local contexts.

The partners were interested in developing more explicit skills in partnership brokerage within the PCP. This will require investment in and support for the development of partnership skills with staff and Board. It requires a new language to describe, assess and make sense of the work of PCPs, to enable all stakeholders, including DHHS, to have greater understanding of and appreciation for their impact and value.

Attribution and contribution of reported PCP work has been raised as a tension for some partners. Reporting that is more clearly focused on the role and contribution of the PCP partners would capture this value add, enhance understanding of the role of PCPs and more explicitly articulate how the partnership approach has contributed to broader health outcomes is required. This would also enable a clearer distinction between the role of PCP as a platform and that of its partners.

This reporting will need to capture the complexity and processes for brokering, managing, and supporting the partnerships that enable health outcomes. The authors acknowledge the challenges of capturing rigorous and valid data in a context where decision makers are more conversant with more quantifiable, empirical clinical data. However, there is a well-established practice in capturing the value, contribution and impact of processes such as the roles fulfilled by PCPs. The framework at Annex 5 offers an example of one such framework.

Clarifying and ensuring the position, identity and role of PCPs in an ever-changing landscape of health reform and strategy will be a critical consideration of any reform. This will need to be part of ongoing considerations by DHHS in close collaboration with PCPs.

> *'The Government needs to acknowledge that rural communities need this resource – it was imposed on us but we can make better use of it, it can be very powerful – we can't afford to let it go, we have acknowledged we need it to work better but we need it. '*

Based on the findings of this report, we encourage you to consider the following recommendations when reviewing the PCP platform:

1. PCPs should be regarded as the key partnership platform for health and cross sector agencies to address place-based health responses within their catchment.

2. A clear endorsement be made by Victorian Government affirming their support of the PCP platform and clarifying the roles and responsibilities of DHHS (Regional and Central Office) with particular reference to PCPs. Actions to be taken to improve DHHS

understanding of and engagement with PCPs.

3. A PCP model needs to acknowledge, accommodate and be adaptable to the different and specific contexts of rural, regional and metropolitan catchments.

4. The PCP governance structure should be determined locally in order to achieve the appropriate place-based response for the catchment. This may include expanding the partnership to include more cross-sector partners, reducing Board numbers and/or introducing a tiered governance structure to ensure effective decision making.

5. DHHS consider additional funding/resources to support the PCP partners to participate in partnership work and incentives to bring disengaged or new partners to the table.

6. PCP catchments should remain small enough to achieve a depth of understanding of the local areas and provide local responses that meet the needs of the community and continue to be adaptive and flexible.

7. Explore a more place-based approach to funding models to reduce interagency competition and align resources with the needs of the community. PCPs Partners and EOs should be engaged in co-designing the appropriate structure for such a model.

8. Recognise and support the development of partnership broker skills as a requirement for PCP staff and executive board members to build, strengthen and sustain the partnerships.

9. Improve resourcing for the VicPCP platform to advocate the role of the PCPs within broader state-wide networks and structures, including newly introduced platforms and partnerships. This would also strengthen the value, role and identity of PCPs through better communication with DHHS and support improved DHHS understanding of the PCP work.

10. PCPs and PHNs to proactively and collaboratively identify and act upon mechanisms to support closer interaction and engagement. This would focus on mutually agreeing respective and complementary roles and contributions to shared outcomes.

11. That a Monitoring, Evaluation and Learning Framework (MELF) be developed for the PCP Model that is appropriate to and focused on the partnership process role of PCPs. The MELF should include monitoring and evaluation tools and reporting metrics to demonstrate the PCP partnership process and value. It is also important to identify an approach to acknowledge the contribution of different partners and roles, as well as measure and report health outcomes.

ANNEXES:

1. LIST OF PARTICIPANTS
2. LIST OF DOCUMENTS REVIEWED
3. BRIEFING FOR DISCUSSION GROUPS
4. CASE STUDIES
5. PARTNERSHIP ANALYSIS FRAMEWORK – AN EXAMPLE

ANNEX 1. PCP PARTICIPANTS

NAME	ROLE WITHIN ORGANISATION	ORGANISATION
Andrew Saunders	CEO	Edenhope District Memorial Hospital
Anne Mc Evoy	CEO	Rochester and Elmore District Health Services
Ben Maw	CEO	Cohuna District Hospital
Bruce Myers	Director Community and Cultural Services	Swan Hill Rural City Council
Callum Wright	Executive Director Organisational Support	Bendigo Community Health Services
Carita Clancy	EO	Ballarat Hospice Care
Chris Kelly	Manager Community Wellbeing	City of Greater Bendigo Council
Dallas Widdicombe	Health & Wellbeing General Manager	Bendigo District Aboriginal C
Dan Douglass	CEO	Heathcote Health
Danielle Trezise	Community Integration Manager	Beaufort Skipton Health Services
Darren Clarke	CEO	Boort District Health
Dianne Couch	CEO	Castlemaine District Community Health
Dianne Sartori	Senior Manager Ballarat Goldfields	West Vic Primary Health Network
Dorothy Stone	Senior Manager Primary Health & Aged Care	Kyabram Health
Emmanuel Geri	Director of Nursing	Robinvale District Health Service
Francis McCormick	Clinical Nurse Educator, Psychiatric Services Professional Development Unit	Bendigo Health
George Mudford	General Manager Southern Mallee	Mallee Family Care
Ian Fisher	CEO	Castlemaine Health
Janice Radrekusa	Executive Director Regional	Murray Primary Health Network
Jenny Harriot	Community Programs Manager	Bendigo Health
Jerri Nelson	Director of Community Development	Buloke Shire Council
Joanne Gell	Strategic Director	Ballarat Health Service, Grampian Integrated Cancer Services
Jody Croft	Primary Health Manager	Mallee District Aboriginal Service
John Koopmans	Manager	Department of Health and Human Services
Karen Liang	A/CEO	Kyneton District Health

NAME	ROLE WITHIN ORGANISATION	ORGANISATION
Karen Stevens	Director Community Wellbeing	Macedon Ranges Shire Council
Kath Day	General Manager People and Community Support	Grampian Community Health
Laura Martin	Wimmera Grampians Regional Manager	West Vic Primary Health Network
Lisa Knight	Director, Economic and Social Development	Mount Alexander Shire Council
Lois O'Callaghan	CEO	Mallee Track Health and Community Service
Mandy Hutchinson	CEO	Northern District Community Health
Margaret Augerinos	CEO	Centre For Non Violence
Margaret MacDonald	CEO	Cobaw Community Health
Melissa Morris	Health Promotion Officer	Women's Health Grampians
Naomi Goode	Manager Community Strengthening	North Grampians Shire Council
Ngarela Melgre	Community Health Manager	Rural North West Health
Nick Bush	CEO	Echuca Regional Health
Paul Mc Kenzie	Regulatory & Community Services Division General Manager	Campaspe Shire Council
Paul Smith	EO	Swan Hill District Health
Paula Noble	Primary Care Manager	East Wimmera Health Service
Rose Miles	Manager Carer Support Services & Deaf Access LMR	Bendigo Health
Sally Philip	Director Community Services	East Grampians Health Services
Stacy Williams	Director	Gannawarra Shire Council
Suzanne Barry	CEO	Community Living and Respite Services
Tim Shaw	EO	Wimmera and Southern Mallee LLEN
Tracey Wilson	CEO	Inglewood and Districts Health Services
Tracy Chenoweth	Executive Director	West Wimmera Health Services
Trevor Adem	CEO	East Wimmera Health Service
Tricia Currie	CEO	Women's Health Loddon Mallee
Wendy Gladman	Director Community Wellbeing	Loddon Shire Council

ANNEX 2. DOCUMENTS REVIEWED

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ANNEX 3. BRIEFING FOR DISCUSSION GROUPS

Primary Care Partnerships Victoria
Independent Program Review
Briefing Paper for PCP Governing Groups and PCP teams
Rhonda Chapman Independent Partnering Advisor

Introduction

Please allow me to introduce myself. My name is Rhonda Chapman and I am an independent partnership broker, advisor, coach, trainer and community worker with 30 years experience in the international and national community sectors. I have been asked by the Loddon Mallee Primary Care Partnerships (PCPs) to undertake a review of the PCP model ahead of the Department of Health and Human Service (DHHS) review of the platform, anticipated in 2019.

Carolyn Neilson is assisting me with the discussion groups. Carolyn formerly worked with the Central Victoria PCP and has extensive experience in community development, gender equity and social inclusion and participatory research.

Purpose

The purpose of the review is to support the DHHS to make an informed decision about the future partnership model for a place-based approach. The review will provide evidence based on the practice and experience of seven rural and regional PCPs. It will aim to assist the PCPs demonstrate how they have delivered a place-based model, as well as celebrate the diversity of PCPs and support them to tell their stories.

Approach – Method, Rigour and Ethics

Two facilitated discussion groups will be conducted with each PCP – one with the governing group of partners, one with the PCP team. These conversations will be confidential, using a process of critical questions to prompt conversation and responses. I will facilitate these as the independent advisor.

Notes (rather than a direct transcript) will be taken at each discussion group with the opportunity for participants to verify the notes in real time. I will also record the discussion as a back up to the notes – these records will be deleted at the finalisation of the report.

The notes from all discussion groups will be collated, synthesised into common themes and a qualitative interpretive analysis undertaken to identify key findings and recommendations. The synthesis and analysis will not be attributed to individuals or organisations to ensure confidentiality. However, if PCPs have examples of practice that can be used to illustrate the findings, you will be asked if we can include a brief case study. No case studies will be included without express permission of the PCP concerned.

A final report will be prepared, a draft of which will be shared with participants for verification and comment ahead of finalisation and sharing with DHHS. The approximate time frame for submitting the final report to DHHS is end January 2019.

All data collection and analysis will be conducted according to the principles of good partnering and participatory practice.

Questions

The questions we will be considering at the discussion group are listed below. There is no need for you to provide me with responses prior to meeting but I do encourage you to consider these ahead of the discussion group.

1.In your own words, how would you describe your PCP in practice (don't cheat and copy the description from the website – I want your own perspectives!)?

2.In your experience what has worked/is working well with the PCP? (This can include structure, process, activities, relationships – think broadly)

3.In your experience what has not worked/is not working so well with the PCP? (This can include structure, process, activities, relationships – think broadly)

4.If you could determine the next version of the PCP, what would it look like?

ANNEX 4. STAFF CASE STUDIES

1 We could see the partnership trust within the project "Unborn Children At Risk", to hear the bad stuff along with the good, honesty, gaps, what we're not doing well. If this project sat with one of the partners, we wouldn't have the same level of openness. If any one health service or community health service was running the project you would not get the same response because respondents are wary of agendas. And this project was big and heavy but people were able to be honest and say we're not doing as well as we should, that's big. Even though all the partners were in the room the fact that they have funded an independent team to facilitate the project across all these players has really helped the project.

2 The work that a PCP staff member does on the community prevention plan- the one plan – is very important. It reduces some of the work load of the agencies because the PCP staff member brings them together, writes the plans, does the data analysis, with them– collaboratively, but she does the grunt work and so when it came to reporting, it's there in the one plan, so it significantly reduces their workload and has changed something. They can easily recognise their work in the work that we (PCP staff) do, they have strong ownership of the plan and it is a good collaborative process. From this work they recognise now that what happens at a network level is something that they can report on – and this has changed – they realise that all this work as a network was not always recognised previously. I don't think people see it as PCP reporting on it we're just helping with the reporting.

3 PCPs provide enormous value with a small amount of funding – the ripple effect. For example, we're working with our local Indigenous organization on a local indigenous project. They are running the project and PCP staff have brought in partners and networks that we are aware of, which has had some amazing outcomes. It came from a small grant to test an idea they had, which was to test a mobile health clinic. We have supported some community engagement, sourced funds and brokered a partnership with a university to fund a van, because it is a training opportunity for their students. We are now recruiting a coordinator to coordinate the van. There wasn't funding from State or Federal Government but funding has been matched by PHN. We feel we have played a critical role to get it going.

4 I think for me the biggest impact we have had where we had no financial input was the LGBTQI regional network. Through this project we developed a relationship with the DPC equality branch, to the point where we are getting random phone calls from around Victoria about this LGBTQI work we have done. The only cost has been my time and we have been getting lots of interest from state government departments and see significant change in the region in just two years through this initiative. This project is one of the first of its kind in Australia around peer support training and engagement for transgender and diverse people. I never thought in my wildest dreams I'd be on first name terms with the Commissioner for Gender and Sexuality and half of her team.

What stunned me as an older person was seeing all the old male mayors going along to the LGBTQI roadshow and I was thinking "this is a huge change". They were happily engaging in conversations. The changes in the last two years has not just blown my mind and it has blown the LGBTQI community minds. Both Councils have agreed to raise the rainbow flag on the International Day Against Homophobia, Biphobia, Intersexphobia and Transphobia.

5 The Family Violence project has worked well because we have funding and someone (PCP staff) driving it across the partnership. Many people comment that you need a driver. The fact that the driver is a local who has personal connections – all makes a difference.

We have some work to do with some of the organisations who were part of the initial funding application – partners who have gone a little bit missing in the work. But because Family Violence is an identified community focus or issue, it has been very community driven with other organisations on board and hitting the mark in terms of social determinants of health.That endorsement from the community, the partnership and someone to drive it is very important.

ANNEX 5. PARTNERSHIP ANALYSIS FRAMEWORK – AN EXAMPLE

PARTNERSHIP BROKERS ASSOCIATION
CRITICAL SUCCESS FACTORS FOR HIGH LEVEL COLLABORATION

Efficiency / Effectiveness

- Clear, well articulated shared vision
- Consortium / collaboration is well managed with role descriptions, clear accountabilities and regular reviews for any staff / consultants
- Consortium / collaboration has strong / appropriate communications in place
- There is senior management buy-in from each partner organisation
- Systems in place to support a collaborative approach

Approach

- All those involved have understood and acknowledged what each organisation brings to the collaboration
- Individual expertise and preferred ways of working are understood and incorporated consciously and constructively
- Those involved are flexible (whenever and wherever they can be) and clear about their constraints / 'non-negotiables' (if there are any)
- Collaboration processes are understood and adhered to by all partners
- Programmes of work are jointly designed and implemented or are undertaken on behalf of the wider group by agreement / mandate
- Partners have a genuine voice at the table and their contribution is respected

Attitude & Competencies

- Individuals involved have the necessary collaboration mind set
- Individuals involved have the necessary knowledge and skill set
- There is tangible evidence of each organisation's engagement – including clear and informed handovers to those new to representing their organisation at the Consortium
- Willingness to devote enough time to relationship building, development and maintenance

Results / Productivity

- The consortium / collaboration is highly action / results oriented
- Individual organisational goals are achieved whilst also achieving shared goals
- The consortium / collaboration is maximising value to each organisation involved – and this is measured
- Through joint advocacy, consortium / collaboration is achieving wider impact & influence

MAKING THE INVISIBLE VISIBLE

A REPORT INTO THE PARTNERSHIP APROACH OF SEVEN RURAL & REGIONAL PRIMARY CARE PARTNERSHIPS IN VICTORIA

JANUARY 2019

CO IMPACT