phn BRISBANE NORTH

An Australian Government Initiative

steady invested strong

A Consortium and Commissioning Toolkit

BRISBANE NORTH PHN | SEPTEMBER 2016

Brisbane North PHN gratefully acknowledges the financial and other support from the Australian Government Department of Health.

Disclaimer

Brisbane North PHN disclaim all liability for errors or omissions of any kind whatsoever, or for any loss or damage in whole or in part, arising from any person relying on any information in this document.

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Prepared by Karen Wing

Contents

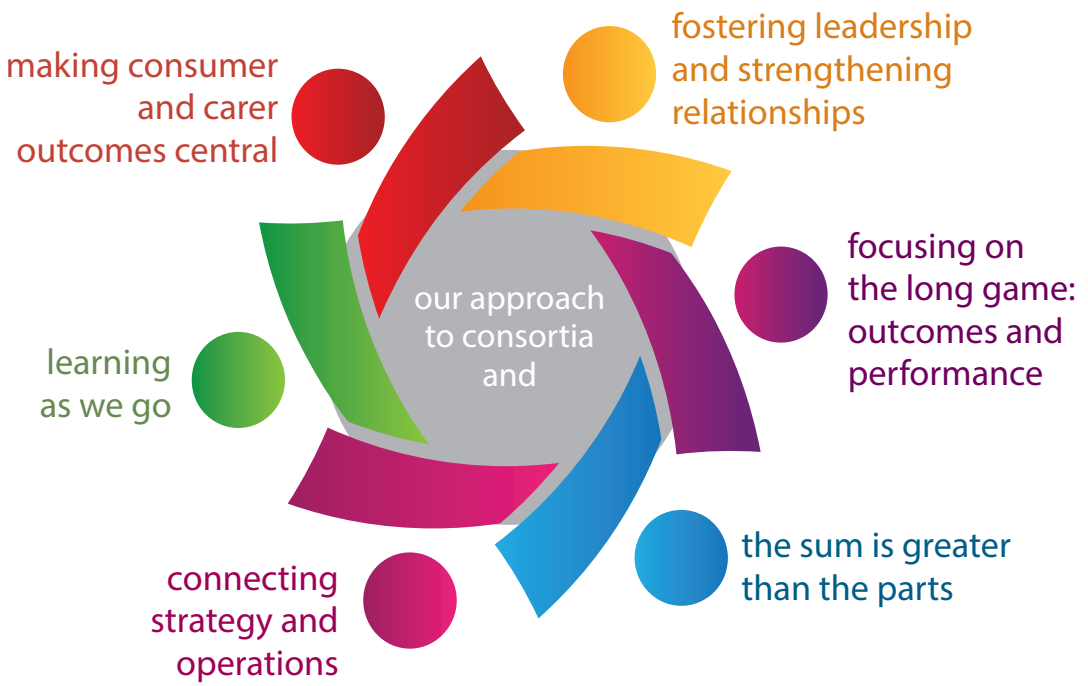
List of abbreviations and acronyms

CANSAS	Camberwell Assessment of Need Short Appraisal Schedule
CHSP	Commonwealth Home Support Program
CMC	Consortium Management Committee
CIMS	Consumer Information and Management System
DSS	Department of Social Services
HACC	Home and Community Care Program
IT	Information technology
KPIs	Key performance indicators
MOU	Memorandum of Understanding
HHS	Metro North Hospital and Health Service
MAC	My Aged Care
NDIS	National Disability Insurance Scheme
NGOs	Non-government organisations
PiR	Partners in Recovery
PiRO	Partners in Recovery organisation
PHN	Primary Health Network
QUT	Queensland University of Technology
RAS	Regional Assessment Service

Executive summary

About this Toolkit

This Toolkit tells the story of collaborative work undertaken by Brisbane North PHN, in conjunction with our partners, through three Consortia. We link this work directly to the PHN's objective of commissioning and achieving integrated healthcare outcomes. We tell this story by outlining our experience, that of our partners and by including resources we hope others may find useful in their collaborative work. Below we provide a precis of each Section of the Toolkit and list resources and practice examples included in each Section.



Our story

We have worked in collaboration with Metro North Hospital and Health Service (the HHS) and a range of non-government organisations (NGOs) to establish three Consortia:

- Brisbane North PiR Consortium was established in late 2012 in response to potential Australian Government funding. PiR brought with it integration through care coordination and innovation through a focus on improving the service system for people experiencing mental illness.
- healthy@home was established in early 2013 in response to a regional opportunity for service provision by NGOs. healthy@home's first task was to transition 3,500 clients previously receiving services from the HHS to NGO service providers within a five-week period.
- Brisbane North RAS Consortium was established in response to the Australian Government's My Aged Care (MAC) reforms. The setting for this Consortium was that of national reform to community aged care based on a philosophy of consumer choice and a streamlining of business processes and service delivery to allow for ready consumer access.

Our approach

There are a number of factors that have been fundamental to our approach and so are part of our story. We focus on these factors in describing our story in this Toolkit: making consumer and carer outcomes central; strengthening relationships and fostering leadership; focusing on the long game; the sum is greater than the parts; connecting strategy and operations; and learning as we go.

Commissioning and collaboration

As part of their role in improving coordination of healthcare, PHNs are tasked with 'commissioning' a range of healthcare programs and services. PHNs across Queensland have described a Commissioning Framework that outlines how this will occur that is outlined in this Section along with two commissioning strategies that our work with Consortia align most closely with: service design and co-creation; and competitive dialogue. We also discuss the role of the lead agency in Consortia.

2.6.1 Choosing co-design and competitive dialogue

2.6.2 Designing the lead agency role

Starting off

Starting work on developing a Consortia means tackling three key aspects: understanding needs and priorities; establishing a purpose and agenda; and choosing partners and a structure. We explore these aspects in this Section.

3.6.1 Co-design case study: Brisbane North PiR

3.6.2 Choosing partners checklist

3.6.3 MOU mud map

3.6.4 Crafting contracts checklist

3.6.5 Gearing up for good governance

3.6.6. Conditions of collective success and good governance

Staying steady, invested and strong

Our experience is that once collaborative work has got off to a good start, a deliberate approach is needed to keep partners' effort, engagement and investment steady and strong. In this Section we outline strategies we have used to sustain effort and engagement.

4.5.1 Consortia in aged care: A framework for success

4.5.2 Partnership survey snapshots: PiR and healthy@home

4.5.3 Service delivery models for RAS and PiR

Focusing on the long game

Together with our Consortium partners we have worked hard to focus on the 'long game' by creating and sustaining a performance oriented culture; by focusing on quality and by learning as we go. In this Section we explore how we have done this.

5.4.1 QlikView: PiR's reporting system

5.4.2 Sample RAS Client Satisfaction Report

5.4.3 PiR Learning Circles

5.4.4 Refresh and review timeline

5.4.5 PiR's local evaluation elements

The sum is greater than the parts

Fundamental to our approach is a belief that the sum is greater than the parts. Engaging partners adds value and helps us to deliver integrated healthcare and the work we have done in conjunction with partners in our three Consortia provides ample illustration of this. In this Section we explore four aspects of this: planning for the future together; working as part of the broader healthcare sector; integrating outcomes; and influencing policy. Together these aspects help us to identify future directions for our collaborative work.

6.5.1 healthy@home Strategic Plan

6.5.2 Brisbane North PiR forum 2015

Future directions

Between 2012 and August 2016, our work in establishing and sustaining the three Consortia we have used as practice examples in this Toolkit has provided strong foundations for our approach to collaboration as a PHN. Research for this Toolkit tells us that both PHN managers and our partners have found the experience to be enriching, immensely developmental in nature and sometimes exhausting. Feedback provided through research was overwhelmingly positive but showed that Consortia members see substantial changes in their future environment and believe that new and different work will need to be undertaken to face these challenges as well as to continue their collaborative effort. Some Consortium members also identified other settings that they felt this collaborative approach could contribute to including service provision as part of the National Disability Insurance Scheme (NDIS); delivery of mental health services other than PiR; alcohol and drug treatment programs; service coordination for special needs groups; and advocacy for older people.

1. Introduction

1.1 About Brisbane North PHN

The Australian Government has tasked Primary Health Networks (PHNs) with improving coordination of healthcare to ensure people receive the right care in the right place at the right time as well as with focusing on mental health and aged care as two of their priorities.[1]

As part of the national network of PHNs, Brisbane North PHN connects healthcare for people living in the region covering Brisbane City Council suburbs north of the Brisbane River, all of the Moreton Bay Regional Council and parts of the Somerset Regional Council around Kilcoy. Our region is home to 941,533 people and this population is projected to increase to 1,272,370 residents by 2036.[2]

Since 2012, Brisbane North PHN has done extensive collaborative work with the Queensland Government's Metro North Hospital and Health Service (the HHS), with NGOs providing mental health and/or community aged care and with consumer and carer representatives to achieve strong and integrated outcomes for people in North Brisbane and Moreton Bay. We have led three Consortia that deliver strong outcomes in mental health and community aged care: healthy@home; Brisbane North Partners in Recovery (PiR) Consortium; and the Regional Assessment Service (RAS) Consortium.

1.2 Our partners

To establish and sustain these three Consortia we have worked with many partners. In the table on the following page we list the organisations and consumer and carer representatives who are part of the three Consortia we are proud to lead.

1 http://www.health.gov.au/PHN and http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Background

2 Page 7, Brisbane North PHN, 2015/16 Health Needs Assessment. April 2016.

Consortium	Partners
healthy@home	• Brisbane North PHN
	• Metro North Hospital and Health Service
	• All About Living
	• BallyCara
	• Burnie Brae
	• Carers Qld
	• Centacare
	• Co.As.It
	• Communify
	• COTA
	• Footprints
	• GOC Care
	• Institute for Urban Indigenous Health
	• Jubilee Community Care
	• Leading Age Services Australia Qld
	• Nundah Activity Centre
	• Aged and Disability Advocacy Australia
	• RSL Care/RDNS
	• Wesley Mission Queensland
Brisbane North PiR Consortium	• Brisbane North PHN
	• Metro North Hospital and Health Service
	• Aftercare
	• Communify
	• Footprints
	• Open Minds
	• Mental Illness Fellowship Queensland
	• Neami National
	• Richmond Fellowship Queensland
	• Institute for Urban Indigenous Health
	• Queensland Alliance for Mental Health
	• Consumer and carer representatives: Jan Kealton; Tina Pentland; Cassandra Loane; Emma Davidson; and Tyneal Hodges.
RAS Consortium	• Brisbane North PHN
	• BallyCara
	• Centacare
	• Co.As.It
	• Communify
	• Footprints
	• GOC Care
	• Institute for Urban Indigenous Health

1.3 About this Toolkit

This Toolkit tells the story of collaborative work undertaken by Brisbane North PHN, in conjunction with our partners, through three Consortia. We link this work directly to the PHN's objective of commissioning and achieving integrated healthcare outcomes. We tell this story by outlining our experience, that of our partners and by including resources that we hope others may find useful in their collaborative work.

This Toolkit is intended to be a practice-based resource rather than a theoretical discussion of collaboration and integration but we also include material that has helped us to describe, understand and improve our work along the way as well as relevant references to our current context as a PHN. Our experience of collaborative work focuses on "creating place-based systems of care" using "collective action across systems and local communities."[3] This Toolkit presents to you the work we have done through these three Consortia that has helped build place based care in Brisbane North and Moreton Bay.

Because our focus in this Toolkit is on sharing approaches that have been successful for us in our collaborative work, we include at the end of each section some resources and practice examples that illustrate our work in practical ways and that we hope others may find informative and useful.

1.4 How we developed this Toolkit

This Toolkit was developed in conjunction with our partners in the three Consortia we deliver health care outcomes through, using the following methodology:

- establishment of a project plan outlining our objectives and the outcomes we sought from the project
- engagement of an independent consultant to prepare the Toolkit
- targeted research to identify and review relevant resources to be used in development of the Toolkit
- design and conduct of a workshop with the three Consortia and the PHN that road tested a draft Table of Contents for the Toolkit and elicited perspectives and stories about formation and operation of the Consortia to be used in the Toolkit
- conduct of phone and face to face interviews with Brisbane North PHN managers and Consortia members to ascertain personal perspectives to form part of documenting the experience of establishing the Consortia
- conduct of a workshop to test the Toolkit's contents and approach with disability providers in Northern Sydney considering development of a joint service delivery model in the context of NDIS[4]
- preparation of this Toolkit.

3 Drawn from a presentation by Dr Rachael Addicott, Head of Research at The Kings Fund entitled Commissioning and Strategic Planning: Lessons from international research presented to the March 2016 National PHN Forum that can be found at http://www.health.gov.au/internet/main/publishing.nsf/Content/00069147C384180DCA257F14008364CB/$File/Commissioning-The%20Kings%20Fund.pdf

4 Workshop attendees represented three organisations - Northside, NBI and the Housing Connection.

2. Commissioning and collaboration

Metro North Brisbane Medicare Local has since transitioned to Brisbane North PHN as part of national changes to strategic healthcare directions that have included establishment of PHNs.

In mid-2012, in response to the Australian Government's Invitation to Apply for PiR funding, the then Metro North Brisbane Medicare Local took the first steps towards establishment of a Brisbane North PiR Consortium. Since then three Consortia, two delivering community aged care and one delivering mental health services, have been established and now successfully deliver services. We outline the early story for each of the three Consortia below.

2.1 Our story

Brisbane North PiR Consortium was established in late 2012 in response to potential Australian Government funding. PiR brought with it integration through care coordination and innovation through a focus on improving the service system for people experiencing mental illness. The hallmarks of this Consortium include comprehensive early work to establish strong foundations; continued commitment by a core group of members; excellence in consumer and carer involvement; and strong PiR outcomes. Early Consortium milestones are outlined below, followed by perspectives shared by Consortium members as part of research for this Toolkit.

August 2012	The Australian Government's Department of Health issued an Invitation to Apply for PiR funding and Brisbane North PHN commenced work on bringing together a Consortium to seek funding for PiR.
October 2012	Brisbane North PHN engaged an initial group of service providers in preliminary work on options for a Brisbane North PiR model. Ideas from this work were used to consult with a broader range of consumers, carers and service providers. 28 consumer and carer representatives and 71 representatives of service delivery organisations participated in consultation to build on initial work and inform the proposed PiR model.
November 2012	Consortium partners were selected and the Brisbane North PiR Consortium was established. The Consortium consisted of ten organisations, seven of whom were specialist mental health organisations, with the PHN as the lead agency, Metro North Hospital and Health Service (HHS)[1] and Queensland Alliance for Mental Health as the industry peak organisation. Consumer and carer representatives were also involved directly in the governance structure.[2]
December 2012	Brisbane North PHN submitted a response to the Invitation to Apply.
Early 2013	The Brisbane North PiR Consortium continued meeting to further develop their potential PiR model, to ready for implementation and to strengthen their partnership model, including through establishment of a Memorandum of Understanding (MOU), whilst awaiting advice about PiR funding.
April 2013	Brisbane North PHN was notified it had been successful in its bid for PiR funding.
May to October 2013	Further work occurred to finalise the service delivery model, PiR staff were recruited, and an IT system and policies and procedures were established in preparation for go-live of PiR in October 2013.

Table endnotes

1 The regional health authority established by Queensland Health with responsibility for delivery of clinical mental health services.

2 The Consortium has since expanded with the addition of an eighth service delivery organisation, Institute for Urban

Indigenous Health, an Indigenous organisation with a high level of expertise in Indigenous health care.

What PiR Consortium members said about their experiences

> "I think we were really excited about working collectively. I think the model required that and that was fantastic. My memory is that we worked through lots of workshops about ideas and issues and challenges. It was a lot of work to get us to where we are today."

> "My first real recollection was the big consultation for PiR before the actual tender had been released when we started that community engagement over in North Lakes and I remember being in that massive space with lots of people and lots of tables and lots of butcher's paper and a huge amount of speculation and it was very exciting because it was new and it was what we were anticipating for the future."

> "For me it was really exciting to see that we would drop some of those service silos and really do something better and different. I think that actually has been achieved. I think the second thing is that the development of the relationship, irrespective of the organisational silos, has been really strong for me."

> "When we started we had no idea so I always really like that…it was sort of exciting and it was breakneck."

> "The Consortium had already gathered when I was recruited and my first perspectives were about, wow, what a whole heap of work has been already been done here and we had three months to operationalise it and there was still a whole heap to do but still really excellent foundations were there."

> "I came on board when the PiR staff had been recruited and things were at an embryonic stage and I think what I recall of that was the real structure that was trying to be held around all these different players and staff in all different places and how the PHN really holds that and what are all the rules. Lots of meetings were around all of that."

healthy@home was established in early 2013 as the Brisbane North Home and Community Care (HACC) Consortium in response to an opportunity for service provision by NGOs as a result of Metro North HHS relinquishing its HACC contracts.[5] healthy@home's first task was

5 The Consortium was originally called the Brisbane North HACC Consortium and is now called healthy@home. To avoid confusion, the Consortium will be referred to as healthy@home from this point in the Toolkit.

to transition 3,500 clients previously receiving services from the HHS to NGO service providers and to simultaneously put fee for service arrangements in place within a five-week period. This remarkable feat was followed by an increase in the number of outputs delivered through the available funding allocation in healthy@home's first year of operation. The Consortium prides itself on its ability to give consumers choice by providing high quality generic services and services focusing on the needs of specific demographic groups of older people including those from culturally and linguistically diverse backgrounds, Indigenous people and people who are homeless or at risk of homelessness. The Consortium's early milestones are outlined below, followed by perspectives of Consortium members shared as part of research for this Toolkit.

Late 2012	Metro North HHS indicated it would relinquish its HACC contracts. As a result, the funding agency for HACC, then the Australian Government's Department of Social Services (DSS), decided to seek alternative arrangements to ensure continuity of service provision. Brisbane North PHN and a number of community aged care service providers began discussion about a Consortium approach to service provision along the same lines as the PiR Consortium's approach. Brisbane North PHN met with all organisations currently delivering HACC services in the region to discuss bidding for funding using a Consortium approach. The PHN then conducted a selection process with all interested regional HACC-funded organisations to identify organisations to participate in a PHN-led Consortium. As a result, 16 organisations were invited to participate in the Consortium.
January 2013	healthy@home was established with the intent of bidding for funding to deliver CHSP[1] services in North Brisbane and Moreton Bay. The Consortium consisted of seven (now 19) organisations committed to providing quality services to older people including: • Brisbane North PHN as lead agency • Metro North HHS • member organisations providing quality services to older people in their homes • member organisations with an expert understanding of the needs of older people and of carers as well as of the aged services industry.[2]
February 2013	A funding bid was submitted to DSS.
April 2013	The PHN was awarded a contract for CHSP services in Brisbane North, with delivery occurring through healthy@home.[3]
May–June 2013	healthy@home transitioned 3,500 CHSP clients to new NGO service providers who were part of the Consortium in a five-week period. At the same time, fee arrangements were established with consumers, in line with DSS's requirements.
July 2013	The then Minister for Mental Health and Ageing, Senator the Hon Jacinta Collins, launched this new model for the Australian Government's then HACC program.

Table endnotes

1 When the Consortium commenced organisations were funded through the HACC program. As at July 2015, DSS issued program guidelines for the Commonwealth Home Support Program (CHSP) which replaced the HACC program. To avoid confusion, we will refer to the program as the CHSP program from this point on in the Toolkit.

2 Since that time two additional service delivery organisations have joined healthy@home increasing the total number of organisations participating to 19.

3 The Consortium was originally called the Brisbane North HACC Consortium and is now called healthy@home. To avoid confusion, the Consortium will be referred to as healthy@home from this point in the Toolkit.

What healthy@home Consortium members said about their experiences

"I got involved in late 2012 when there was information coming out that community health centres, as they were then, would relinquish their HACC contract and so there were small organisations who were coming together and participating in this. I would say that from the early days, if it hadn't been for PiR, this Consortium would never have come together because there were people from PiR involved. So it was an exciting prospect for us to be able to participate in a contract like this."

"We were excited by the opportunity. Luckily we had an opportunity, we were in a meeting when the possibility of PHN taking this on was mentioned. We knew what we were up against and we all made the decision to have a go and I don't think we regret it."

"When I started the CHSP contract hadn't quite landed and so the first meeting for me was daunting and exciting. Although we all thought, yes, collaboration is a good idea, we were faced with a huge task of transitioning about 3,500 people in ridiculous timeframes, in five weeks. It was all about that at the start."

"We became involved when the HACC transition started, along with other consumer and carer organisations. It was great that the PHN saw the importance of having consumers' input into what was happening, so that was exciting."

"It was a mad scramble at the start. It was like being part of a going concern. There was the opportunity to share knowledge and wisdom and benchmark. Though we are increasingly competitors, given consumer directed care, it actually brings together organisations."

"3,500 clients were transitioned over a five-week period when we started. This was the first highlight. It really worked. Incredibly, we achieved it.

It was an extraordinary achievement! I thought, wow, we can really do things! I still can't believe we did that."

> "My first impression was what a great model. Not only a great justification to have a Consortium model because of the transition of consumers and wanting to be part of that and ensuring that smaller providers were able to pick up business. But also just the notion of who was selected and who was on board. The Consortium model served a purpose but there was more to it than the original purpose because we saw the opportunities for us all creating a fantastic group of people who could be anybody we wanted to be and look at projects. All the diversity in the group—people with special needs are provided with good services. Regardless of us all being Brisbane North, everyone has their localised services and it's been great for consumers."

Brisbane North RAS Consortium was established in response to the Australian Government's MAC reforms. The setting for this Consortium was that of national reform to community aged care based on a philosophy of consumer choice and a streamlining of business processes and service delivery to allow for ready consumer access. Reforms were happening on every front – government and NGO service delivery; phone, internet and IT platforms; and radically re-engineered business processes. Change on such a large scale meant the Consortium had to deal with rapidly evolving national implementation and needed to swiftly adapt their service delivery model as change occurred. At the same time, Consortium members had to modify their own organisations' business processes to take account of the nationally driven designed process. Early Consortium milestones are outlined below, followed by perspectives of Consortium members shared as part of research for this Toolkit.

October 2014	In October 2014, DSS issued a Request for Tender inviting organisations who wished to auspice a RAS to respond. RASs were to be part of an overall service provision system called MAC, a national gateway to aged care services. The main components include: a national call centre, a website, a central client record and assessment services. DSS specified a detailed business process for how RAS was to work within the MAC environment, including that there needed to be separation between assessment services and other service delivery. healthy@home Consortium members agreed to form a separate Consortium to bid for RAS funding that would be led by the PHN. Seven healthy@home organisations joined the PHN in this Consortium to deliver RAS.
November 2014	A service delivery model for RAS was developed collaboratively and a response to the Request for Tender commenced.
December 2014	A response to the Request for Tender was submitted.
April 2015	The Consortium received notification of their successful bid for funding as a RAS service. The Consortium was one of only 13 RAS organisations funded across Australia.
April–June 2015	Preparation for go-live was completed including implementation planning; recruitment, selection, induction and training of staff; and development of localised procedures and IT systems.
July 2015	Go-live of RAS occurred on 1 July 2015.

What RAS Consortium members said about their experiences

"I thought they [RAS Consortium members] were brave. When we asked who would be interested, it was recognised there was not enough funding for all and people self-selected quite easily. Seven organisations [including the PHN] volunteered and the rest said go ahead."

"I was called on board as the RAS Consortium was being put together. That was a really interesting process because there were really contracted timeframes. It was really good to see this RAS Consortium put together with already the spirit of established collaboration and even though it was quite challenging because the response time to the Department, even though they were looking for Consortia, it put a challenge on how we could even get proper consultation. And yet because everyone was so established in their roles of collaborating, I think that we could actually meet those expectations. I thought that that was the first and most amazing thing to see."

"And then to get to be one of the 13 organisations across the nation! To have that opportunity was quite exciting and very uncertain."

"Timeframes were ridiculous, totally unreasonable, but we got it over the line. I think we expected it would be difficult. It was major change: new IT; not much sector preparation; everyone was unclear about how it would work. This is the only program I've worked on where, when we revisited risk assessment a few months in, all the risks were red and were outside our control. And they all happened. The true Consortium test has been RAS because if that doesn't break a Consortium nothing will. Throughout all the difficulties and the financial drivers about being lean, the Consortium members have all worked well together. Everyone has worked really closely with the philosophy that ours is going to be a good quality service. You know, that integrity. This wouldn't have happened if there hadn't been a good, previous, collaborative experience with CHSP. There couldn't have been such a cohesive and integrated approach across seven agencies without this. They are getting quite close to integrated in RAS. They are sharing and working together and not relying on us [lead agency] for this. For example, when a tsunami of referrals came through, organisations worked together to sort it out rather than just ringing us."

"In the RAS formation, I am a very big advocate for consumer choice because I think there is such alignment with the broader role of PHN and the alignment with primary healthcare and the healthcare system."

2.2 Our approach

The stories in section 2.1 show that the context for, and experience of, the three Consortia differ markedly. However, there are a number of factors that have been fundamental to our approach and that are part of our story. We describe these factors below.

Making consumer and carer outcomes central

Our role as a PHN is to work with others to connect and improve healthcare in the region we work in. To achieve the right healthcare outcomes, we need to understand the perspective of those using healthcare and engage them in planning and designing it as well as giving us feedback on how it works for them. This has been a fundamental plank in our three Consortia. We have achieved this using mechanisms such as direct consumer and carer representation in governance structures; involving organisations who represent consumers and carers; undertaking evaluation using consumer and carer representatives to seek authentic feedback from their peers using the service; and service satisfaction surveys.

Fostering leadership and strengthening relationships

One of the critical factors in supporting the three Consortia to grow and flourish has been ensuring that a focus on strengthening relationships and fostering leadership has been in place both in the PHN and in partnering agencies. We have used a range of strategies to achieve this including a focus on strengthening our own work as a lead or 'backbone' organisation; professional development and training for Consortium members, including in adaptive leadership; effective governance structures and processes; and review mechanisms assessing how relationships are travelling.

Focusing on the long game

Achieving outcomes and making sure performance focuses on these outcomes is our way of focusing on the long game. Consortia approaches are sometimes stereotyped as focusing on relationships rather than on the task at hand – achieving strong outcomes. Instead, our approach is to keep our sights clearly on the outcomes we want to achieve and on

how improving our performance can help us achieve these outcomes. To do this, we have worked on establishing and maintaining good data sets that, in turn, enable good performance data to be generated; on keeping performance front and central in our governance structures; on building a 'self-regulatory' approach with our partners rather than creating a 'master-servant' relationship; on ensuring robust working relationships allow open discussion about performance; and on reviewing and adjusting funding allocations between Consortium members when needed to realise the best healthcare outcomes.

The sum is greater than the parts

Fundamental to our approach is a belief that the sum is greater than the parts. That is, that engaging partners adds value and that we can work to realise this value. We have actively used frameworks such as collective impact and co-creation and design to aid our understanding, and that of our partners, about how to achieve this value add. We have also focused on making diversity between partner organisations work, in terms of the variety of consumer groups and service delivery types partners offer expertise in.

Connecting strategy and operations

We focus on strategy and on applying strategy to operations. We work to ensure that strategy is clear; that operations align with it; and that our governance structures provide the opportunity to engage decision makers in strategy and operational staff in how to apply strategy effectively to service delivery. We have done this through governance structures that engage both decision makers from partnering organisations and operational staff with responsibility for delivering services; through ensuring our role as backbone or lead agency supports work on both fronts; and through ensuring agendas are balanced between strategic and operational decision making and information sharing. Conversely, we use outcomes and data from operations as an input to ensure that strategy is well grounded in the consumer experience.

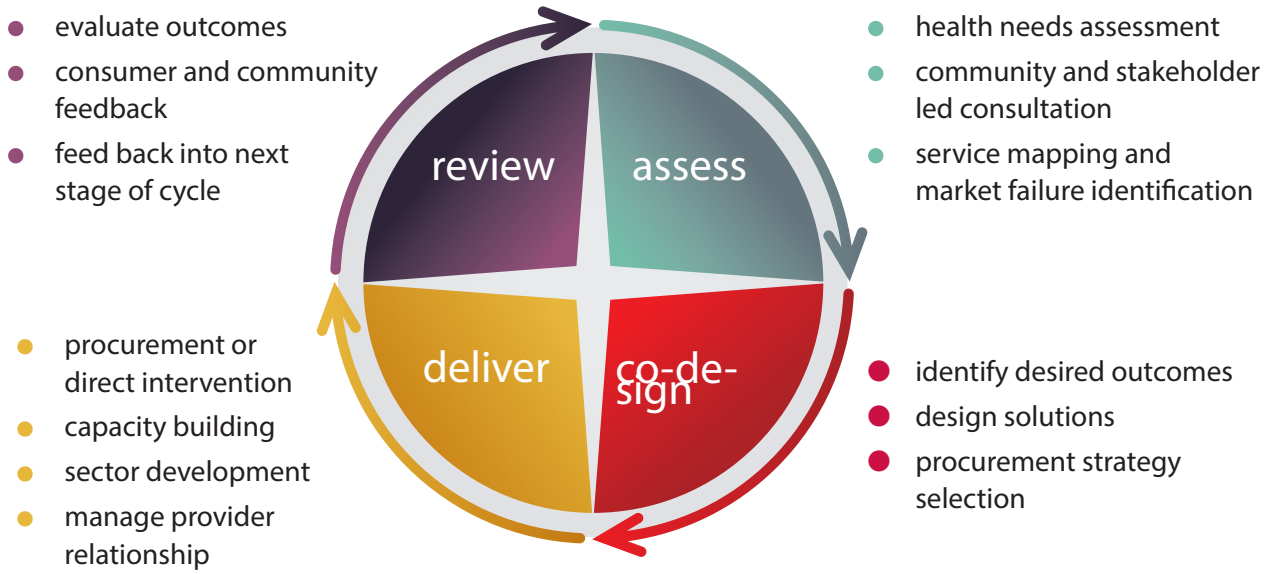
Learning as we go

In conjunction with our partners, we have worked hard to embed a culture that is about learning as we go and about quality service delivery in all three Consortia. We have done this through including a quality practice role in our backbone organisation role; through implementing quality mechanisms; through staff information exchange at an operational level; through a range of 'refresh and review' mechanisms; and through a robust focus on evaluation at a local level as well as participation in program-wide evaluation and advisory structures. Our early experience has served to inform new and fresh approaches as we continue our collaborative work. As a result, each time we work with partners to establish a new Consortium, we are each able to benefit from our learnings from earlier collaborative work.

2.3 Commissioning and PHNs

As part of their role in improving coordination of healthcare, PHNs are tasked with 'commissioning' a range of healthcare programs and services. PHNs across Queensland have described a Commissioning Framework that outlines how this will occur. This Framework defines commissioning as:

- committing limited resources to health and community care interventions with the aim of improving the health system and delivering better consumer outcomes. Commissioning relies on robust relationships and established trust at the local level
- commissioning is a needs-led and outcome-evaluated process. Stakeholders work to identify needs and co-design solutions. The procurement of services is only one possible outcome to the commissioning process
- commissioning underpins all areas of the PHN's work, including analysis and planning, support for GPs and other healthcare providers and purchasing health and community care interventions.[6]



The Framework also identifies an on-going cyclical process that informs commissioning as well as principles that underpin it. This approach to commissioning is underpinned by the following principles:

1. Understand the needs of the community by analysing data, engaging and consulting with consumers, clinicians, carers and providers, peak bodies, community organisations and funders.
2. Engage with potential service providers well in advance of commissioning new services.
3. Put outcomes for users at the heart of the strategic planning process.
4. Adopt a whole of system approach to meeting health needs and delivering improved health outcomes.

6 Drawn from the document endorsed by Queensland PHNs "What is commissioning?" and adapted from What is world class commissioning? by Michael Sobanja at http://www.medicine.ox.ac.uk/bandolier/painres/download/whatis/What_is_WC_Comm.pdf

5. Understand the fullest practical range of providers including the contribution they could make to delivering outcomes and addressing market failure and gaps, and encourage diversity in the market.
6. Co-design solutions; engage with stakeholders, including consumer representatives, peak bodies, community organisations, potential providers and other funders, to develop evidence-based and outcome-focused solutions.
7. Consider investing in the capacity of providers and consumers, particularly in relation to hard-to-reach groups.
8. Ensure procurement and contracting processes are transparent and fair, facilitating the involvement of the broadest range of suppliers, including alternative arrangements such as consortia building where appropriate.
9. Manage through relationships; work in partnership, building connections at multiple levels of partner organisations and facilitate links between stakeholders.
10. Develop environments high in trust through collaborative governance, shared decision-making and collective performance management.
11. Ensure efficiency, value for money, and service enhancement.
12. Monitor and evaluate through regular performance reports; consumer, clinician, community and provider feedback and independent evaluation.[7]

> "As a PHN the benefits [of collaborative work] are significant. We can build good working relationships across the sector. We gain understanding and have influence and an interface between health and social services. An active role gives you an incredibly good platform for this. We have a great knowledge of issues for consumers and service providers, can do better advocacy for consumers and providers and better capacity building. Consumers need choice so our support of small to medium sized service providers is important in terms of sector changes that are locally connected and socially inclusive. We don't want a duopoly of service providers. Collaboration needs to be built for these service providers to survive. We also need to have a policy voice back to government - got to be in there. If we sat outside, we would not be as successful at all this because we have an actual reason to work together and so you build much more productive relationships."

7 Drawn from Op cit, "What is commissioning?" and adapted from the National Audit Office of the United Kingdom at https://www.nao.org.uk/successful-commissioning/general-principles/

2.4 Commissioning and collaboration

The Framework outlined above describes commissioning as not just about procurement but instead as forming part of a cycle that assesses community needs and designs responses to meet those needs. Work underway by the Australian Government to inform commissioning by PHNs proposes that commissioning may utilise a range of strategies for procuring responses to community need.[8] To identify when to use collaboration, it is important to understand how it may be incorporated into some of these commissioning strategies.

The three Consortia we are part of, in conjunction with our partners, align more closely with two of a number of possible commissioning strategies: service design and co-creation; and competitive dialogue. In Section 2.6.1 we illustrate how our collaborative work links to these strategies and suggest when these approaches may useful.

2.5 The role of lead or commissioning agency

Research for this Toolkit painted a clear picture of the importance of the role and capability of the lead agency. Feedback from partners demonstrated they valued two strongly complementary capabilities in a lead agency—that of fostering leadership and resilient working relationships and that of establishing and sustaining effective governance structures and processes. Fostering leadership and working relationships is explored in Section 4 and getting governance right is discussed in Section 3.

The three Consortia we lead use language derived from the collective impact approach to describe and understand their work, including use of the term 'backbone organisation' to describe the PHN's role. This term is used by Kania and Kramer as one of the five descriptors that together form 'five conditions of collective success' and is defined by them as an organisation that supports collective work through staff who can "plan, manage and support the initiative through ongoing facilitation, technology, communications support, data collection and reporting."[9] We outline below some of the perspectives articulated by Consortium members on the PHN's role as the backbone organisation.

What partnering organisations and consumer and carer representatives said about the backbone organisation

> "They are really solid and really committed. They come at it from a values perspective. Of course dollars matter, but I don't feel that is front and centre. Commitment to regional improvement is a very genuine motivator - not just holding you to the contract because they have the power but instead holding you to account about the outcomes. The PHN is not just telling [partnering organisations] but has an openness to hear from community."

8 Department of Health, phn Commissioning: Designing and Contracting Services Guidance, Draft 2, Department of Health. March 2016.

9 Pages 39 and 40, Kania and Kramer, Collective Impact in Stanford Social Innovation Review, Winter 2011.

"It's fantastic that they are not delivering [services] so there is no conflict there. They are making decisions being able to look at the interests of all parties including the clients. That is another really important thing that the PHN does - the client is front and centre of decision making. It's not just about business, it's about what is best for the client which doesn't happen too often. They are pretty committed to it. So, if there is ever any debate, that is where you go back to. They are not delivering the business so they are very fair about division of resources."

"They are very honest about performance. They have had those conversations with under performers – it hasn't been kept in the closet. Not pointing, just here are the facts and the numbers. It's based on evidence. Sometimes they have had a private discussion sideways. When it's been a significant performance issue, it's been on the table, you can see it in the numbers."

"Fantastic. When they kicked it off they were so enthusiastic, so open and set a great example. They have showed real leadership in the way the PHN has handled things. I think that this whole program is wonderful. I've spoken with people in other Consortia and they are a bit lukewarm – I suspect there wasn't full buy in and commitment."

"I think they are really fantastic. I can imagine what they have to do in order to sustain all of us and the decision making. They still have a number of the responsibilities – funding, KPIs, quality. They are very professional."

"There is value in working with a high performing, polished PHN. This has been executed very well. E.g., IT stuff, marketing and communications stuff, engagement. We also need to challenge and fully realise the connecting point to GPs, primary healthcare and hospitals. There are still silos on this. That's the bit we need to continue to drive - better connection and integration."

2.6 PRACTICE EXAMPLES AND RESOURCES

2.6.1 Choosing co-design and competitive dialogue

Much of our collaborative work aligns with co-design and co-creation or competitive dialogue processes. In the following table we define these commissioning strategies, provide examples of how we have used them or been influenced by them and identify when we have found these commissioning strategies useful. It is important to note that in the following examples, Brisbane North PHN operated both as a proponent responding to government funding processes and as a lead agency commissioning services from other NGO partners.

Commissioning strategy[1]	When we have found this approach useful	What we have done that aligns with this strategy
Designing services, including co-creation involves potential providers in designing specifications and solutions.[2]	• when stakeholder expertise or involvement will help design the program or service that best responds to community needs • when there are many available options and the one that best meets community needs must be selected • when an initiative has partnership or service system objectives (e.g., change to the larger service system, delivery of integrated outcomes or streamlined referral pathways) • when program or service design needs to be transparent to stakeholders who have a high level of investment in its outcomes • when the capacity of stakeholders likely to deliver the program or service can be enhanced through participating in co-design and co-creation.	• Initial work with a small number of potential PiR partners on a model informed broader co-design or consultation process that, in turn, informed partner selection. • We brought CHSP service providers together to discuss the idea of a Consortium. Partners were selected and co-design was used to plan the partnership approach. • Initial discussion with healthy@ home partners identified a subset of organisations interested in designing a regional model for RAS and delivering it via a Consortium.
Contracting using competitive dialogue allows bidders to develop alternative proposals in response to an outline of requirements.[3]	• when a consultation process involving partners and others is needed to outline the program or service before partners are selected • when partner selection needs to take into account service delivery capability and partnering capability • when partners need to support the common agenda developed through co-design.	• After co-design work with potential partners, we sought indications of interest from organisations about being part of each Consortium. • Potential partners expressed interest based on a good knowledge of the planned model and whether it suited their approach. • Parameters for selecting partners were identified through co-design and then used to assist in selecting partners.

Table endnotes

1 Drawn from page 21, phn Commissioning: Designing and Contracting Services Guidance, Draft 2.

2 Drawn from page 21, ibid.

3 Drawn from page 32, ibid.

2.6.2 Designing the lead agency role

The following extract is from the MOU for healthy@home and outlines the role and responsibilities of the PHN as lead agency in the healthy@home Consortium.

Role of Brisbane North PHN as lead agency in healthy@home*

Brisbane North PHN is the lead agency for delivery of CHSP services through the Consortium. Its role includes:

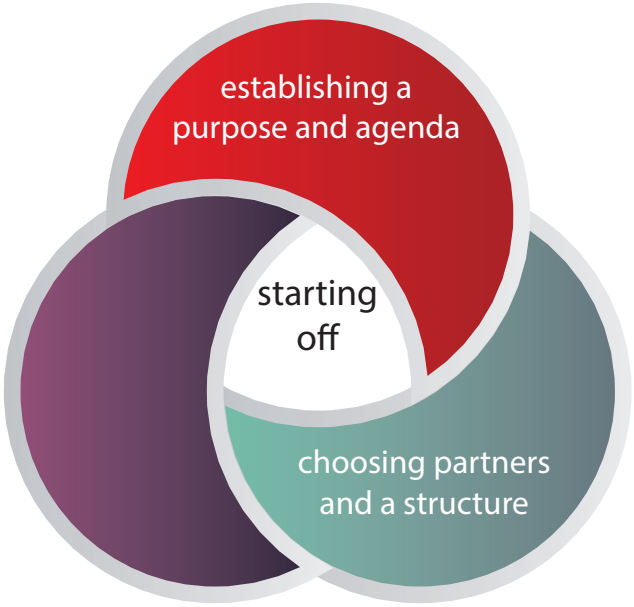
- providing leadership that fosters an environment that:
  - identifies broader opportunities for providing community aged care services
  - links the Consortium's services to primary healthcare services for older people
  - focuses service delivery on the consumer and the outcomes they need
  - delivers high quality services based on evidence about what works for older people
  - enables learning and development to support better community aged care services
  - responds to the needs of diverse groups of older people such as Indigenous people, people from different cultural backgrounds and people who are homeless or at risk of homelessness
  - enables collaboration
- overall responsibility for, and governance of, the model used to deliver CHSP services by the Consortium
- overseeing and monitoring quality delivery of CHSP services by the Consortium
- creating and maintaining effective partnerships and relationships with and between a diverse range of stakeholders relevant to the delivery of CHSP and to aged care generally
- commissioning services (distributing funding, getting agreements and arrangements in place)
- contributing to the collective leadership and management capability of the Consortium
- developing, overseeing and monitoring CHSP's governance and accountability arrangements, performance management model and partnership arrangements
- development, operation and monitoring of the healthy@home Management Group (HMG) and the CHSP Coordinators Group (the Coordinators Group) as governance and service delivery mechanisms for CHSP
- developing suitable planning, policy and practice frameworks for CHSP in conjunction with Consortium members
- leading an annual planning process to identify future priorities for the Consortium and establishing a reporting framework to measure progress against these priorities by the Consortium
- liaison with the funding body and overall responsibility for reporting to them and ensuring compliance with their requirements.

*Extract from Memorandum of Understanding: An agreement between members of the Brisbane North CHSP Consortium, December 2015 – June 2018.

The checklist on the following page uses our experience to list some considerations in designing the role of lead agency, as well as some questions that help determine the approach that works best in different settings.

Lead agency roles and responsibilities	Questions for consideration
Fostering the right environment.	• What is the lead agency's role in providing leadership to the Consortium? • How can the lead agency role help ensure there is a strong focus on outcomes that best meets community and consumer needs? • How can the lead agency link partners effectively to relevant policy directions, funding agencies and the broader healthcare system? • How can the lead agency support growth and positive responses to change by the Consortium?
Governance structures and processes.	• What governance structures are needed? • How should they operate? • What role should the lead agency take in governance structures? Should these structures be convened and supported by the lead agency? • Should the lead agency chair governance structures or would an independent Chairperson value add to governance structures?
Commissioning and contracting.	• Is the lead agency also the commissioning agency? How should these two roles interact and how should any tensions between the two roles be managed? • What is the role of the lead agency in establishing contractual arrangements? • How does resource allocation occur and what are the respective roles of the lead agency and partners in this?
Quality.	• What work is needed to ensure the Consortium delivers quality outcomes and services? • Is work on quality part of the role of the lead agency or is it undertaken by other partner(s)? • How does this link to resource allocation and contractual roles?
Leading a focus on outcomes and performance.	• What is the role of the lead agency in reporting and monitoring outcomes and performance? • If challenges with performance occur, what is best discussed through the Consortium's management structure and what is best discussed with individual partners? • How should management level and operational staff play a part in focusing on outcomes and performance? What is the lead agency's role in facilitating their involvement?
Strategy and planning.	• What is the role of the lead agency in working with partners to develop the Consortium's strategic direction and in planning for the future of the Consortium?
Managing external relationships.	How does liaison with funding agencies occur and what is the role of the lead agency in this? Are protocols needed for handling media and other external stakeholders and what is the lead agency's role in this? Are mechanisms for working with providers external to the Consortium and with the broader sector needed?

3. Starting off



Starting work on developing a Consortia means tackling three key aspects: understanding needs and priorities; establishing a purpose and agenda; and choosing partners and a structure. We explore these aspects in this Section.

3.1 Understanding regional needs and priorities

Establishing a Consortium, or other collaborative initiative, must be based on a clear understanding of regional needs and priorities and of how collaboration will value add to responses to these needs. For us, as a PHN, this is about ensuring our collaboration reflects both national priorities for PHNs (e.g., mental health and aged care) and priorities identified in North Brisbane and Moreton Bay through our Health Needs Assessment (e.g., responding to the higher prevalence of mental illness evident in Moreton Bay North).[10] It is also about identifying why collaboration, for example establishing a Consortium, will value add to responses to priority healthcare areas. Our Consortia value add by supporting our objective of connecting healthcare and providing mental health and community aged care in a more integrated way across the region.

> "We [the PHN] get a value add for consumers by virtue of providers working more closely together and so getting better models, workforce models and improving their services. The providers share really well and break down siloed work. They get to look at other services and see how they could do better. There are shared training groups, referrals are made to other services. There is also more consistency and access to a broader range of services. You get more consistency across services because providers have access to a broader range of services and this works well and so they refer consumers to other services. There are shared training opportunities. This reinforces the whole networking, sharing stories effect."

10 Op cit, Page 9, Brisbane North phn, 2015/16 Health Needs Assessment.

The following examples illustrate how our Consortia have explored and realised opportunities to achieve more integrated healthcare outcomes and so have added value to what we do:

healthy@home

The community aged care sector is characterised by many and diverse service providers and national reforms are intended to streamline referrals and achieve better access to services by consumers and carers. healthy@home has worked on more streamlined referral pathways for older people and their carers and considerable enhancement of referral pathways between agencies has been achieved. Having 13 service providers as part of healthy@home working on service delivery together provides a natural method for realising these outcomes. In addition, healthy@home has provided the basis for further partnerships demonstrating integrated outcomes between sub-sets of Consortium members including in provision of transport and transitional care.

RAS

The six service delivery agencies in the RAS Consortium participate in the nationally designed MAC arrangements and so use the same business processes and assessment tool. This requires effective co-ordination and well-developed knowledge of partner organisations. Research for the Toolkit showed a number of examples of integrated work including targeted referrals between organisations when specialist expertise is required (e.g., working with Indigenous people, with people from culturally and linguistically diverse backgrounds and people who are homeless or at risk of homelessness) and close coordination to respond to fluctuating volumes of assessments.

The PiR Consortium

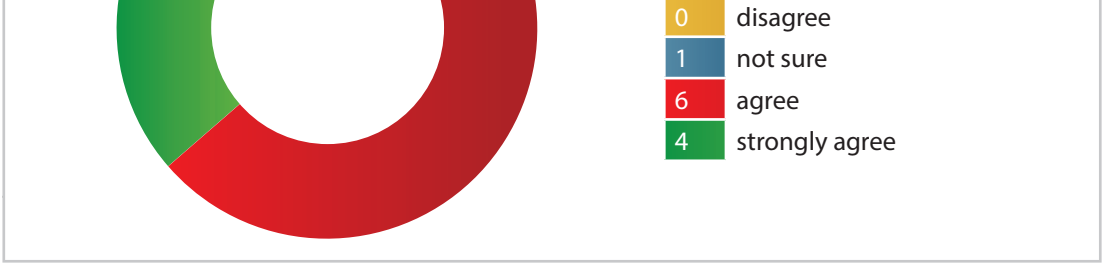
The PiR Consortium's service delivery model funds eight service delivery organisations to operate a highly cohesive PiR model. This cohesion is supported by a common service delivery model and operating procedures; a shared IT system with data analysis and reporting capability readily available to workers in all eight agencies; a capable quality function located in the PHN; a shared intake function; and strong governance structures at a management and service delivery level with focusing on building relationships and on performance.

3.2 Establishing a purpose and agenda

Establishing a clear purpose and agenda is critical in early work towards a Consortium as well as in sustaining collaboration over time. Each of our Consortia was formed in response to a specific opportunity with the potential for collaboration to realise better outcomes across the region. This allowed for a crystal clear purpose to be established early in each Consortium's history. This, in turn, supported design of the best structure for each Consortium and partner selection.

An illustration of the importance of clarity of purpose and agenda is provided by early perceptions of PiR Consortium members about their partnership. In April 2014, a confidential, on-line survey was conducted to gather baseline data on the PiR partnership.[11] 11 Consortium members responded. All respondents agreed or strongly agreed there was a

11 The survey was based on The partnerships analysis tool. Victorian Health Promotion Foundation. Melbourne. 2011.



11 respondents indicated there was a shared understanding of, and commitment to, this goal amongst partners. All respondents also agreed or strongly agreed that the partners were willing to share some of their ideas, resources, influence and power to fulfil this goal.

More recently, as part of research for this Toolkit, when workshop participants drawn from the three Consortia were asked to rank how important various factors are to collaboration, shared aims or goals were ranked as by far the most important factor. Consortium members interviewed in preparation for this Toolkit shared their thoughts about how the three Consortia are going in terms of having a 'common agenda' in place.[12] These thoughts are included below.

What Consortium members said about having a common agenda

> "We are at a really interesting crossroads because things are changing to lots of new spaces. We had a really good common agenda and we will need to re-clarify and re-find this in the next while and find its [the Consortium's] new common agenda. There is a challenge for that moving forward as we are really dealing with an end of project life now."

> "Absolutely, I think the fact that all the partners were already delivering similar services. This wasn't new business; it was just a joint business approach. We have a joined up approach when we were already doing that business independently. I think collectively we could go a lot further around efficiencies and supporting each other as this goes forward. There is more work that we can do but we have laid great foundations for collective decision making."

> "Brilliantly, because there is a fundamental understanding of what we are there to do. It doesn't actually go off track because people know what they need to do."

> "We are getting sharper and sharper. It's really about looking at what's out there, what's our core business, about assisting older people in the community to stay in the community."

3.3 Choosing partners

12 Op cit, Page 39, Kania and Kramer. A common agenda is one of Kania and Kramer's five conditions for collective success.

Alongside establishing a clear purpose and agenda, finding the right partners is an essential ingredient to the success of any collaborative venture. Some of the factors we have taken into account in partner selection are outlined below.

Getting the right expertise and experience at the table

Early development work needs to identify what types of organisations are needed and partner selection needs to ascertain whether interested organisations have the right profile and expertise. For us, relevant aspects of an organisation's 'profile' have at times included size and scale, geographic footprint and office locations. Examples of expertise required have included the type of services that organisations are proficiently delivering (e.g., community aged care or mental health services) and/or expertise in delivering services to particular demographic groups (e.g., Indigenous people and people from culturally and linguistically diverse backgrounds).

Being part of a collaborative venture

Partners require more than just the right service delivery experience to be a successful part of a Consortium. Experience and expertise in collaboration are also required as well as commitment to this style of working. For example, when selecting partners, we have asked organisations about their experience and approach in collaborating with other organisations as well as about their willingness to work with us as a lead agency.

Understanding what the region needs

Choosing the right partners also ensures we have a firm foundation in terms of understanding the region's needs. For example, in selecting PiR partners, we wanted organisations who had an existing footprint delivering mental health services in Brisbane North. Our intent was that organisations would be familiar with the region's demography and service system as well as the needs of people experiencing mental health issues in North Brisbane and Moreton Bay. This helped us to hit the ground running.

Building partner capacity

Choosing partners can also be about building their capacity. Organisations may at times lack some aspects of experience required as a partner and the lead agency may make a deliberate choice to work with these partners to build their capacity and expertise. This is illustrated by the PHN's Commissioning Framework that is guided by "principles of good commissioning" derived from the National Audit Office in the United Kingdom. These principles propose that a commissioning agency may choose to "invest in the capacity of the provider base, particularly those working with hard-to-reach groups."[13]

Supporting diversity and consumer choice

One of our objectives in utilising the Consortium approach is to sustain the number and diversity of organisations delivering healthcare services to ensure consumers have a real choice about accessing services. Inherent in this approach is the inclusion of small to medium service providers who gain from the Consortium's robust backbone arrangements and scale and who may otherwise struggle to compete with larger stand-alone organisations. Our approach in sustaining diversity has included partnering with organisations of diverse size and scale and actively seeking organisations who deliver services to specific population

13 Drawn from Op cit "What is commissioning?" and adapted from the National Audit Office of the United Kingdom at https://www.nao.org.uk/successful-commissioning/general-principles/

groups. For example, our RAS Consortium offers both generic service delivery expertise and 'niche' expertise by providers who specialise in delivering services to specific demographic groups. This is illustrated by a partner with specific expertise in working with Indigenous people and by two partners who offer service delivery tailored to meet the needs of people from culturally and linguistically diverse backgrounds, including through an impressive array of languages spoken by staff.

Consumer and carer participation

We value the inclusion of consumers and carers, and organisations representing them, in designing and delivering healthcare outcomes through our Consortia. We have achieved this through including consumers and carers, or those who represent them, in both layers of the governance structures for our three Consortia. Having this in place from the start has been central to our approach and has served as a touchstone ensuring that our services are focused on the best outcomes for consumers and carers. Choosing partners who can represent consumers and carers will vary from field to field. For example, in PiR we have done this through inclusion of individual consumer and carer representatives who have well-developed networks and expertise on the consumer or carer perspective. In community aged care, we have included advocacy organisations representing consumers and carers.

Using the right strategies to select partners is also vital. In Section 3.6.2. we provide a Choosing partners checklist we have developed using our experience that is designed to assist lead agencies choosing partners to think about the best selection strategies.

3.4 Getting governance right

Research for this Toolkit showed that Consortium members perceived the right structure and strong governance arrangements as fundamental to the success of Consortia. A sample of views on this from Consortium members is provided below.

What Consortium members said about governance

> "[The Consortium has] regularity of meetings and rigour from the PHN in reviewing frequency of meetings and structure, governance, communication, existing relationships in some instances and developing relationships to build trust. A sense of the value of the sector and of Consortium partners and respect between lead and Consortium partners. This makes the world of difference."

> "[There was] a lot of benefit from the long development time - this allowed for a lot of shared understanding on program and collaboration and there was lots of back end work done and people had invested time in things like meetings and the MOU and other underpinning work.
>
> Excellent foundations were in place to support future work."

> "It's difficult to achieve but critical. The key is having quite a structured approach to it. We have regular meetings; forums; group and one on one meetings at Manager and Coordinator levels. The sum of all this is continuous communication. It takes time and resources. It's important to get the background communication right. Things won't work without that."

> "This set the scene for some really good, thorough work. Choice of lead happened really quickly. Involvement of an independent consultant was important. It all contributed to the quality of the Consortium and the governance arrangements. Not many others we are part of went down the same path in terms of preparation. This made a big difference. It was useful to have independence and a sounding board and the number of pieces of work done in the lead up to the funding. Lead in time was critical and really set the foundations for the governance structure, which is the most coherent structure we are part of in Queensland."

> "I've been involved in other forums involving service providers who traditionally compete and must collaborate. In comparison, this is very comfortable and is strong. E.g., when there was some funding left over, there was a proposal and there was a sense of how to benefit the group and of growing collaboration; of ground rules; and of a common vision."

> "It was a very tightly held and a very tightly chaired group. It had real structure from the lead agency and there were expectations from the lead agency. The expectation about participation was clear and of how the program would be overseen operationally. There was some really good collegiality so it was formality but a strong sense of people knowing each other and of engagement. Right from early on there was really good maturity in the conversation. There was the buy in and much higher levels of participation (e.g., CEOs and executives). I think there was a combination of high level people but it was not closed jockeying or unwillingness to share and talk. There was fairly open dialogue and people weren't holding their cards to the chests. This was attributed to the developmental pre-work. Certainly first impressions were a willingness to engage and to think about things at a regional level, the values were palpable and about a willingness to collectively address issues."

A further example of the importance of robust governance, and of the lead agency's role in this is provided by Queensland University of Technology's (QUT's) evaluation of the healthy@home Consortium. The evaluation concluded that the PHN's role in governance was a likely driver for service improvements realised under the model with Consortium members identifying a range of benefits arising from joining the Consortium. These included networking and professional development or training opportunities with other providers, expansion of their client base, greater service flexibility and enhancement of their indi-

vidual business model through collaboration with other providers.[14]

We illustrate the approach we have used to establish robust governance arrangements by outlining in the following table components of the governance model for healthy@home. In Section 3.6.5 we have included more detailed information, based on the same example, that can be used to design or review governance structures.

Component of governance model	How does it work?
healthy@home Management Group (HMG)	The HMG is the central governance mechanism responsible for ensuring healthy@home delivers effective CHSP outcomes for consumers. In formal terms, the Consortium Agreement (see below) establishes the HMG as an advisory structure to Brisbane North PHN. In practice, Brisbane North PHN is committed to working with Consortium members to maximise collaborative decision making at HMG meetings.
Coordinators' Group	The Coordinators Group provides operational leadership that enables better consumer outcomes. Members are operational supervisors in their organisations and focus on ensuring that operations work well and smoothly.
Consortium Agreement	The Consortium Agreement is a legal agreement that was put in place when the Consortium was established that confirms members' agreement to work together and sets out terms and conditions for doing so.
Master Program Agreement and associated schedules	The Master Program Agreement and associated schedules are legal contracts between the PHN and each Consortium member that is allocated funding. Associated schedules set out specific funding allocations and the services to be supplied for each allocation.
MOU	The MOU outlines partnership arrangements between Consortium members. This differs from the Consortium Agreement in that it is not a legally binding document. It also focuses on roles, responsibilities, governance structures and healthy@home's partnership model in more detail.
Business rules	Business rules are included in the MOU and specify how the Consortium will work together on particular aspects of their work. They outline respective roles, criteria that outline how the Consortium will collaborate and the process to be used. Business rules have been developed on resource allocation; performance measurement, monitoring and management; and service integration.
Partnership success indicators	These indicators were developed by the HMG as the basis for assessing the ongoing progress of the partnership between Consortium members. They are included in Section 3.6.5.
healthy@home Strategic Plan	The healthy@home Strategic Plan outlines priorities and goals for the Consortium as well as establishing success indicators to assess progress on these strategies over time. You can see the Plan as a practice example in Section 6.5.1.
Monitoring and evaluation	We have used a range of monitoring and evaluation strategies including: • performance reporting on services provided • service satisfaction measures • collection of baseline data on establishment of Consortium relationships • evaluation by QUT.

3.5 Using frameworks for collaboration

Conceptual frameworks and models (or mind maps) are useful to help describe, under-

14 Page 28, McCreaner, Theroux and Graves, Evaluation of the Metro North Brisbane Medicare Local HACC Consortium Model, The Australian Centre for Health Services Innovation. October 2015.

stand and shape collaborative work. In the following table we list some that we have used or are familiar with as examples, along with some ideas about how they can be used. This is by no means an exhaustive list. There are many other resources and tools you can use to help you work on collaboration.

Mind map	What it is about	You can use this mind map to…
Collective impact.	A method used to guide and shape work by communities who are tackling complex or 'wicked' social problems based on the premise that large scale change requires work together across sectors.[1] There are a range of methodologies and frameworks associated with collective impact including the conditions of collective success[2] and collective impact practice principles.[3]	• understand collaborative work • describe and operationalise your collaboration • measure how you are going • work together to solve wicked problems.
Co-creation.	Co-creation is about actively collaborating with consumers in designing and delivering healthcare.[4] We think it is also applicable to engaging partners in developing collaborative approaches.	• engage consumers in design and delivery • engage other stakeholders in designing and delivering programs and services.
Network analysis.[5]	Describes types of networks and their characteristics as well as collaborative practice elements.[6]	understand how networks operate assess how a network operates and identify how you would like it to operate.
Public participation spectrum.[7]	Lists potential goals of public participation and exemplifies techniques that achieve these goals.	identify how you want to involve broader stakeholders.
Facilitators and barriers to intersectoral linkages.[8]	Lists barriers to linkages between sectors, factors that facilitate intersectoral linkages and mental health initiatives that have had the objective of intersectoral linkages.	identify barriers and facilitators when considering how sectors link. learn about intersectoral initiatives in mental health.
The Collaboration Continuum.[9]	Classifies different types of work together.	help you to understand the work you do or would like to do in the future.
The partnerships analysis tool.[10]	Provides a framework for considering partnerships and assessing how they are going.	gather baseline data about your partnership assess and review how your partnership is going.

Table endnotes

1 Op cit, Page 1, Kania and Kramer. Collective Impact in Stanford Social Innovation Review, Winter 2011.

2 Ibid, Pages 39 and 40, Kania and Kramer.

3 From FSG website at http://www.fsg.org, Sheri Brady and Jennifer Splansky Juster, April 21, 2016.

4 http://frankpiller.com/customer-co-creation/

5 Myrna Mandell, Robyn L. Keast, and Kerry A. Brown, The importance of a new kind of learning in collaborative networks, European Group of Public Administration Conference: The Public Service: Service Delivery in the Information Age, 2-5 September, 2009, Malta.

6 Page 5, Robyn Keast, A Guide to Collaborative Practice: Informing Performance Assessment & Enhancement.

7 https://www.iap2.org.au/resource-bank/command/download_file/id/61/filename/IAP2_Public_Participation_Spectrum.pdf

8 Harvey Whiteford and Gemma McKeon, System-Level Intersectoral Linkages between the Mental Health and Non-Clinical Support Sectors, prepared for Mental Health Services Branch, Commonwealth Department of Health and Ageing.

9 http://www.collaborationforimpact.com/collaborative-approaches/ca-subpage-2/

10 Victorian Health Promotion Foundation, The partnerships analysis tool, Melbourne. 2011.

3.6 PRACTICE EXAMPLES AND RESOURCES

3.6.1 Co-design case study: Brisbane North PiR

The Brisbane North PiR Consortium was established after a comprehensive co-design process resulting in a regional service delivery model as well as specific PiR partners. We provide a summary of this co-design process as a case study below.

Mapping the territory.	Initial mapping of the region was undertaken by the PHN using existing knowledge of the mental health and broader services sector (private sector healthcare providers, government agencies and community services) and advice from a range of stakeholders.
Forging a foundation partnership.	An underpinning partnership was discussed and agreed to between the PHN and the HHS's Metro North Mental Health (the HHS) as the core Queensland Government agency offering mental health services and the largest single provider of mental health services in the region.
Targeted initial consultation.	Invitations were extended to the HHS and a number of community agencies to participate in discussion of early ideas for a model. A briefing paper was developed for use by this group incorporating preliminary ideas for a PiR model as well as questions for discussion. An independently facilitated workshop was held with a number of agencies with specialist mental health expertise, agencies with specialist care coordination expertise and representatives from housing and employment agencies to further develop this model. There were 24 workshop participants.
Region-wide consultation to test initial ideas.	Broader regional consultation was then conducted as part of co-design and included: • development of a second briefing paper which was sent as part of an invitation to an independently facilitated consultation attracting 71 participants representing a broad and diverse range of stakeholders • a further workshop involving 28 consumers and carers who provided robust feedback on the outcomes that PiR should achieve for consumers as well as on the perspective of carers • targeted meetings with 17 stakeholders including representatives from the Royal Australian College of Psychiatrists, the Australian College of Mental Health Nurses and the HHS as a key state government service provider • a final workshop involving 52 participants from a range of organisations and sectors in North Brisbane and Moreton Bay to inform relevant organisations of progress on the model, discuss the mechanism for participation in PiR beyond the Consortium, identify appropriate mechanisms for cross sectoral participation and work on service mapping.

Selecting partners.	North Brisbane and Moreton Bay is a highly populated region with a complex and diverse service system consisting of many community and government service providers. Consequently, interest in becoming a PiR partner was flagged by many organisations during the consultation process. The following parameters guided formation of the initial Consortium and selection of partners: • Bringing together a Consortium of the right size. In a region like North Brisbane and Moreton Bay with many potential PiR partners, it was important to establish a Consortium that maximised engagement but that was not so large that it was impossible to deliver a coherent PiR model. The PHN proposed that in the initial phase of the Consortium 10 organisations should be the maximum. • Getting resource allocation right. The approach identified was to distribute funding resources widely enough to engage partners across the region but not so widely that partners were left with insufficient resources to deliver PiR. Based on initial budget projections and feedback on the model through consultation, the PHN sought seven community agencies from across the region to host PiR teams. • Focusing on mental health. Specialist mental health agencies already delivering services in the region were sought as partners. • Engaging organisations with a diverse scale and footprint. The PHN sought to Include locally focused, state-wide and national agencies as partners. • Serving the whole region. Geographic spread was needed across North Brisbane and Moreton Bay. • Serving diverse population groups. A spread of expertise in working with specific population groups (e.g., people who are homeless or at risk of homelessness and culturally and linguistically diverse people) and with particular service sectors (e.g., employment services and correctional centres) was sought. Once these parameters were established, specialist mental health agencies were invited to express interest in becoming a partner and a number of agencies were interviewed.
Establishing Brisbane North PiR Consortium.	Initial partner selection resulted in seven organisations who were specialists in delivering mental health services and the Queensland peak for the mental health services sector, the Queensland Alliance for Mental Health, joining the PHN, the HHS and consumer and carer representatives to form the Brisbane North PiR Consortium. Since that time, an Indigenous organisation has joined the Consortium, the Institute for Urban Indigenous Health, and has strengthened the Consortium's capability to deliver mental health services to Indigenous people.

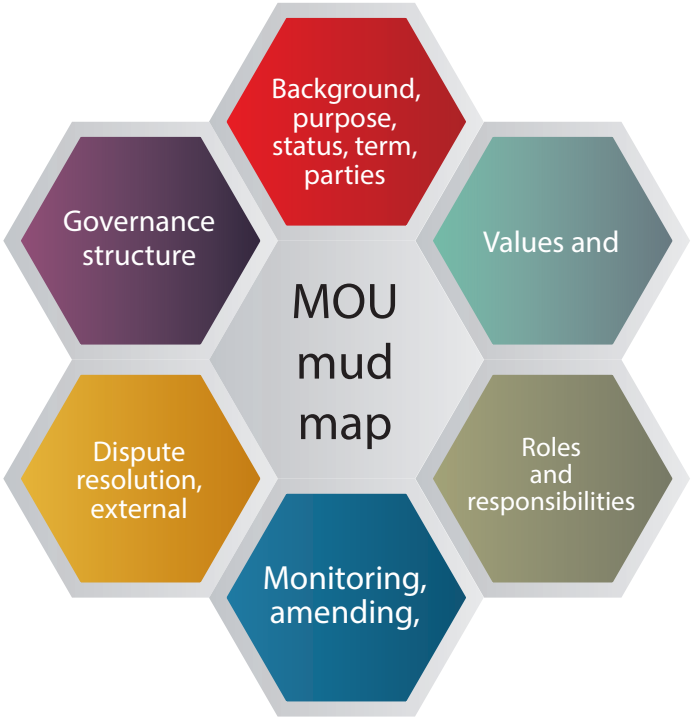
3.6.2 Choosing partners checklist

The following checklist is prepared from the point of view of the lead agency seeking partners to collaborate in a multi-party initiative (e.g. a Consortium). We use our experience to list potential topics for use in partner selection and to frame questions that explore these topics. There are many different ways to explore these topics (e.g., interviews and/or written Expressions of Interest). If you are using a co-design process, you may want to ask stakeholders what is important to them about these topics, so that you have more focused questions for use with potential partners.

Topic	Questions to consider	Examples from our work
What experience, capability and expertise is needed?	• What types of organisations are needed? • Do organisations need to have a particular profile? • What experience and capabilities do organisations need to have?	We needed PiR partners who were able to deliver services across the whole region and our model entailed partnering with specialist mental health service providers.
Are there specific parameters to be considered?	• Are there regulatory or quality regimes that specify who can deliver services? • Does the funding agency specify the program or delivery model? Does this impact on who is best placed to partner?	RAS partners needed to use the nationally designed MAC business processes.
What roles and responsibilities will partners need to fulfil?	• Have roles and responsibilities been specified? Or do we want potential partners to propose options? • Do roles and responsibilities impact on who will be suitable partners?	Our RAS provides specialised services to older people who are Indigenous or from culturally and linguistically diverse backgrounds. That meant we needed partners who were expert at working with these consumers.
How well will partners work with other partners?	• What experience does the potential partner have in collaboration? • What is their approach to it? • What is their commitment to it for this initiative?	For healthy@home we interviewed potential partners and asked them about what value they saw in collaborating on this initiative.
The practicalities.	• Are there particular aspects of the program or model (staffing, reporting) that you need to discuss with potential partners?	The PiR service delivery model included a joint intake function and partners needed to be committed to this.
Value for money and budget.	• Has the budget already been specified for discussion with potential partners? • Do you need potential partners to prepare a budget outlining their costs? • Do partners need to demonstrate they can deliver value for money by outlining their service delivery costs?	A PiR service delivery model was developed, including costings. Potential partners prepared a budget using these costings for discussion with the lead agency.
Governance considerations.	• What governance arrangements are you intending to put in place? • Are there aspects of governance that you need to discuss?	Our three Consortia require partners to participate in a two-layer governance structure.

Topic	Questions to consider	Examples from our work
Due diligence.	• Are there financial, probity or compliance considerations to assess through due diligence? • What are the risks? How can due diligence help to mitigate these?	For PiR, we asked for a standard set of documents to assess.

3.6.3 MOU mud map



MOUs are a common mechanism used when organisations (and sometimes individuals) work together collaboratively. They may stand alone to describe collaboration or may be used in tandem with more formal mechanisms such as legal contracts. We use them in all three of our Consortia. In addition, the PHN has legal contracts in place with partners to whom we allocate funding. In Section 3.6.4 we have included a checklist you might want to use if you are establishing legal contracts.

Above is what we call an "MOU mad map" which lists components you can include in an MOU to shape and govern your collaborative work. In the following table, we list the types of things you may want to cover for each component along with some tips. You also need to think about how you engage partners in discussing an MOU. We have used strategies such as workshops followed by circulating draft MOUs for comment to ensure partners have the opportunity to be involved. It may be useful to discuss other aspects of how the partnership will work when developing an MOU such as the approach you want to use when working together; models that describe the initiatives you deliver together (for discussion of how developing service delivery models can help collaboration see Section 4.5.3); and success indicators for your partnership and the work you are doing together.

MOU component	Things to include	Tips
Background, purpose, status, term and parties.	• Background about why the MOU is being developed and its purpose needs to be included. • MOUs are usually not legally binding and this is referred to as the "status" of the MOU and is included. • The term of the MOU establishes how long it will be in place for. • Organisations and individuals signing up to an MOU are generally referred to as 'parties' to the MOU and are listed in it.	• Make sure you are clear about how long the MOU is in place for, including whether a particular event (e.g., end of a funding contract or advent of a new policy direction) triggers the end of the MOU.
Values and underpinning principles.	• Organisations collaborating through an MOU often identify values or principles that underpin an MOU and 'guide' the tone and nature of the partnership.	• You may want to engage partners in identifying what values or underpinning principles are needed so that they are on board. Think about using strategies such as workshops and working parties to do this. • Outlining values and/or principles in the MOU may help partners later on when they need to identify future ways of working together or resolve challenges in their working relationships.
Roles and responsibilities.	• MOUs usually outline the roles and responsibilities of partners who sign the MOU. • Roles of specific partners may differ and it is important to outline the roles of all types of members. For example, if there is a lead agency, this organisation's roles and responsibilities are usually set out specifically, as are those of consumer and carer representatives.	• Outlining clear roles and responsibilities often avoids problems later on as it helps partners to be clear about what they must do early on. • Roles and responsibilities need to link to the section in the MOU on governance (see below).
Monitoring, amending, reviewing.	• Include sections in the MOU that establish how you will monitor, review and amend the MOU. • You may also want to include 'success indicators' that you collect data on to measure how you are going and use to identify how successful your work is.	• It is important to establish these mechanisms at the beginning so that partners can respond to changes in circumstances by reviewing or amending the MOU. • Make sure you cover off on how to change the parties to the MOU as existing partners may withdraw or you may want to add new partners. • It's healthy to review things. Make sure you include a 'sunset clause' that prompts you to review or conclude your MOU.

MOU component	Things to include	Tips
Governance structure.	• Outline what the governance structure is for your collaborative work. • This may include a description of: – governance structures and a list of their members – how these structures will operate, including any arrangements for chairing meetings – operating guidelines for these structures.	• This is one of the most important aspects of your MOU. No collaborative structure will work effectively without a robust governance structure. • Think about whether you need more than one layer in your governance structure. For example, our three Consortia include a two-layer governance structure so that both decision makers and service delivery staff participate.
Dispute resolution and external communication protocols.	• An MOU usually identifies how any disputes between partners are resolved. • There may be external parties that you want to ensure you have effective communication protocols in place with from the beginning. Common examples include funding agencies and members of the media.	• Including dispute resolution mechanisms from the beginning provides a ready-made option for resolving issues if and when they occur. This may be simpler than trying to retrofit an option if relationships have become tense.

3.6.4 Crafting contracts checklist

Establishing legal contracts to outline deliverables and outcomes and as part of effective governance of the working relationships between the lead agency and partners in a consortium is a common practice and one that we have in place in all three of our Consortia. It is very important to get legal advice when you wish to develop and put in place such contracts. This Toolkit does not provide a legal perspective or legal advice on what such contracts might look like.

Instead, we use our experience to outline some issues you might want to consider if you are developing contracts between lead agency and partners in your consortium. You may also want to consider how different governance strategies can work together to achieve an effective governance structure. For example, for our Consortia we use a combination of contracts between lead and partnering agencies who are allocated funding to deliver outcomes and an MOU that is signed by all members of the Consortium. This means the Consortium's partnering approach can be more fully set out in the MOU and legal issues are outlined in contracts. It also allows for an arrangement that is not legally binding (i.e., the MOU) with consumer and carer representatives who are individuals contributing expertise rather than organisations funded for outcomes and with industry peaks who contribute to the Consortium but are not allocated funding to achieve consumer outcomes. The following checklist proposes some contract components along with some issues to think through for each of these components.

Contract component	Issues to think through
Specifying the outcomes to be delivered.	• The contract needs to set out the outcomes and deliverables that the lead agency is asking the partner to deliver. How this is described will vary and may depend on variables such as any contract the lead agency has with the funding body providing overall funding. This may include the number of consumers a service is delivered to, the type and number of outputs required or specified outcomes.
Role and obligations of parties to the contract.	• The contract will outline obligations of the lead agency with respect to the partner entering into the contract. For example, it may specify that the lead agency will undertake monitoring, reporting and compliance activities. • Partner's obligations under the contract will also be outlined.
Funding allocation.	• The contract will need to establish the funding allocation to be made to the partner. This may be a specified 'block' of funding (e.g., PiR funding is 'block' funding) or a 'unit price' that is paid to the partner once services are provided. For example, RAS funding is allocated on the basis of an agreed unit price per assessment that is paid once an assessment is completed.

Contract component	Issues to think through
Accreditation, quality, audit and compliance.	• Contracts may specify accreditation or quality regimes that partners must have in place. • Contracts often establish the right of the lead agency to conduct an audit of the activities of the partner under the contract. • There may be other compliance requirements set out in contracts. These may be both general and specifically relating to the type of service delivered. An example of a general compliance requirements is insurance. A further general example is provided by a requirement that partners have a system for managing workplace health and safety hazards and risks occurring as a result of services delivered under the contract. • An example specific to CHSP is the requirement that staff working with older people must undergo police checks before they are employed. Such requirements may be set out in the lead agency's contract with the funding body as well as in contracts between lead agency and partners. • Contracts may also specify that the partner's staff need to have the required skills and qualifications. • Contracts may also require that partners have policies and procedures in place that govern their organisation and their service delivery.
Handling consumer complaints.	• Contracts may specify that partners have a complaints handling process in place to handle consumer complaints. • Contracts may also specify that certain types of serious consumer complaints must be advised to the lead agency.
Participation in governance arrangements.	• Consortium contracts may specify that partners need to participate in the Consortium's governance structures. For example, the three Consortia we lead have a two-layer governance process and it is specified in contracts that partners must participate in governance structures as required.
Key performance indicators and reporting.	• Contracts will generally establish key performance indicators (KPIs) as well as identify data that must be collected and reported on. • Other reporting requirements (e.g., financial reporting) may also be outlined. • These requirements may be outlined in schedules to the contract rather than in the body of the contract.
Protocols.	• Contracts may include protocols for handling media inquiries. • Contracts may also include branding protocols or protocols for acknowledging funding agencies.
What to do when significant incidents occur.	• Contracts may require partners to notify the lead agency of any serious incidents that occur. For example, if a partner becomes aware of a significant consumer issue (e.g., significant harm occurring to a consumer while the partner is delivering services), then the lead agency is likely to want to know this has occurred and the contract may specify that it must be reported. • Other serious incidents such as compliance or governance issues may also be reportable.
Risks.	• If a lead agency has entered a funding agreement, there may be some risks associated with doing so. In some circumstances, contracts may pass on such risks to the partner delivering services.
What happens if there is a problem or a disagreement.	• Contracts usually include a process (e.g., a 'show cause' or 'breach' process) that can be used if one party believes there is a problem with the contract. • It is also useful to include a dispute resolution process in the contract that outlines how any disputes under the contract should be resolved.

Contract component	Issues to think through
Timeframes and transition arrangements.	• Contracts will usually specify how long the contract is in place for as well as how parties may terminate them. • Contracts may also specify transition arrangements should the partner want to discontinue delivering services under the contract.
Other aspects.	• There are a range of other aspects that contracts may cover including confidentiality, intellectual property and the privacy rights of consumers using the service.
Legal advice.	• It is critical to get legal advice on preparation of contracts. Your legal advisor will advise you about the terms and conditions you should include.

3.6.5 Gearing up for good governance

The following material is drawn from the MOU that outlines the governance arrangements for healthy@home. You can adapt this material as a resource if you are designing or reviewing governance arrangements for a Consortium or other collaborative venture. This resource follows on from Section 3.4 which provides an overview of healthy@home's governance model.

Key governance structure—role and membership

The HMG is the key governance mechanism for the Consortium and for ensuring that the Consortium delivers CHSP successfully. Its role is to:

- work collaboratively to develop and sustain a shared vision for the Consortium in delivery of aged care services and, in particular, of CHSP services
- develop and implement suitable planning, policy and practice frameworks to enable successful delivery of CHSP and of other activities
- foster an environment within the Consortium that:
  - identifies broader opportunities for providing community aged care services
  - enables collaboration
  - links the Consortium's services to primary healthcare services for older people
  - focuses service delivery on the consumer and the outcomes they need
  - delivers high quality services based on evidence about what works for older people
  - commits to learning and development to support better community aged care services
  - responds to the needs of diverse groups of older people such as Indigenous people, people from different cultural backgrounds and people who are homeless or at risk of homelessness
- consider and take action on expert consumer and carer advice provided by the HMG's consumer and carer representatives
- coordinate, oversee and monitor delivery of the CHSP model for North Brisbane and Moreton Bay
- contribute to the Consortium's governance and accountability arrangements, performance management and partnership arrangements
- establish effective linkages with the Coordinators Group
- participate in an annual planning exercise for the Consortium and contribute to subsequent work
- provide strong collective leadership and management for the Consortium
- take a lead on creating and maintaining effective partnerships and relationships amongst and between stakeholders who work with CHSP's consumer group and in aged care generally
- act as an advisory mechanism that complements and links to the lead agency role and the role of individual agencies
- ensure effective communication mechanisms are in place with Consortium organisations that support delivery of CHSP
- be part of a dispute resolution mechanism to resolve any disputes that occur amongst Consortium members
- support Brisbane North PHN as required in liaison with the funding body.

The HMG is comprised of representatives of the 19 organisational parties to the healthy@home MOU. Organisational representatives are at CEO or a senior level to ensure the HMG is able to make decisions that can be readily implemented by Consortium organisations. Nominees will make their best efforts to ensure continuity of membership and will also, from time to time, include other representatives from their teams to extend participation in the Consortium within their organisation.

Operational leadership governance structure—role and membership

The healthy@home Coordinators Group ensures effective operational leadership and high quality CHSP service delivery by the Consortium. The Coordinators Group reports to the HMG. Its role is to:

- provide operational leadership that fosters an environment that enables better consumer outcomes through:
  - linking the Consortium's services to primary healthcare services for older people
  - focusing service delivery on the consumer and the outcomes they need
  - delivering high quality services based on evidence about what works for older people
  - committing to learning and development to support better services
  - responding to the needs of diverse groups of older people such as Indigenous people, people from different cultural backgrounds and people who are homeless or at risk of homelessness
- provide input to a shared vision for the Consortium in delivery of aged care services and, in particular, of CHSP services
- exchange information and knowledge between Consortium organisations to improve consumer outcomes
- improve coordination and collaboration between Consortium organisations in order to better meet consumer need
- give advice on, and implement, quality improvement strategies and quality measures
- ensure CHSP services are delivered using a consumer and carer focused model and consider and act on expert advice provided by consumer and carer representatives
- commits to learning and development to improve our service delivery
- creates and supports communities of practice to improve our service delivery
- develop a shared approach to service delivery and performance measurement
- share CHSP data to better understand consumer need and provide input to the HMG on its planning, policy and practice work
- provide the HMG with advice on workforce needs and planning
- participate in the Consortium's planning and priority setting in conjunction with the HMG
- establish effective linkages to the HMG
- support Brisbane North PHN as required to effectively deliver the Consortium's CHSP services.

All Consortium organisations delivering services or representing the perspectives of consumers and/or carers commit to membership of the Coordinators Group.

Partnership success indicators

The following success indicators were developed by the HMG as the basis for assessing the ongoing progress of the partnership between Consortium members.

Success indicators for healthy@home and HMG	
We know we will be successful when…	Measured by…
We receive client and carer feedback and act on it.	• examination of findings from QUT evaluation on client satisfaction that are used to improve service quality • minuted HMG discussions about client and carer feedback and action taken • client feedback and participation mechanisms in place • complaints approaches documented and in place.
We partner on other work as well as CHSP.	• annual survey identifies other partnerships developed.
Partners trust each other.	• annual qualitative discussion by HMG evaluating partnership arrangements.
Partnership is between organisations rather than individuals.	• VicHealth's Partnership Analysis Tool • participation of additional members in HMG meetings • participation in Coordinators Group.
Partners are engaged and contributing.	• VicHealth's Partnership Analysis Tool • annual qualitative discussion by HMG evaluating partnership arrangements.
Partners share an annual planning cycle.	• annual planning cycle for CHSP in place which identifies priorities for Consortium's work and feeds into other planning cycles (e.g., Brisbane North PHN's needs analysis).
Our decision making is transparent.	• VicHealth's Partnership Analysis Tool • annual qualitative discussion by HMG evaluating partnership arrangements.
We deal well with difficult scenarios.	• VicHealth's Partnership Analysis Tool • annual qualitative discussion by HMG evaluating partnership arrangements • dispute resolution process used appropriately.
We use relationships to resolve problems rather than contracts.	• VicHealth's Partnership Analysis Tool • annual qualitative discussion by HMG evaluating partnership arrangements.
Partners share resources.	• VicHealth's Partnership Analysis Tool • annual survey identifies joint use of resources.
We assess how our partnership is going each year.	• VicHealth's Partnership Analysis Tool • annual qualitative discussion by HMG evaluating partnership arrangements.
We have performance indicators in place.	• performance indicators measured through annual survey using VicHealth's Partnership Analysis Tool and annual qualitative discussion by HMG evaluating partnership arrangements • performance indicators updated through annual qualitative discussion as required.
We deliver on our allocated outputs.	• performance reporting.

3.6.6 Conditions of collective success and good governance

Many governance frameworks come from an organisational rather than a collaborative approach. Collective impact is a framework that we have found useful to shape and guide our work. In the following checklist you can use the conditions of collective success outlined by Kania and Kramer[15] to design or assess your governance arrangements.

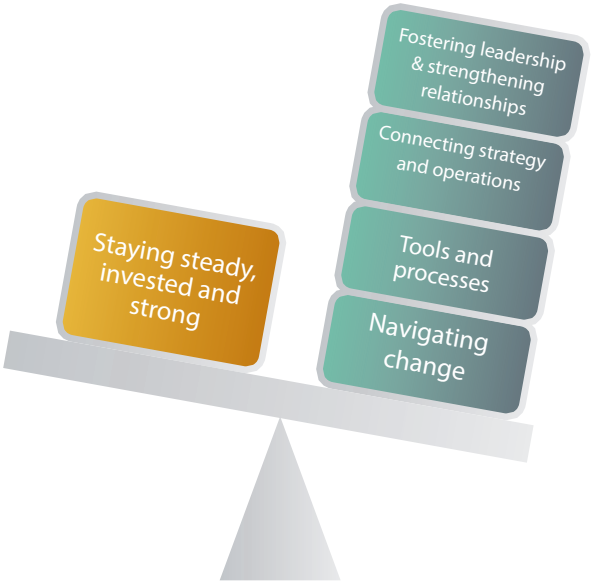
Gearing up for good governance – using the five conditions of collective success[1]					
	What do these conditions of collective success mean for…				
	Governance principles	Governance structures	Governance processes	Governance documents	Monitoring and evaluation
Five conditions of collective success: • common agenda • mutually reinforcing activities • continuous communication • shared measurement systems • backbone support organisation.					

Table endnote

1 Op cit, Kania and Kramer in Social Innovation Review. 2011

15 Op cit, Kania and Kramer in Stanford Social Innovation Review, 2011.

4. Staying steady, invested and strong



Our experience is that once collaborative work has got off to a good start, a deliberate approach is needed to keep partners' effort, engagement and investment steady and strong. In this Section we outline strategies we have used to sustain effort and engagement.

4.1 Fostering leadership and strengthening relationships

Research for this Toolkit shows that partners value greatly the focus on fostering leadership capability and strengthening working relationships amongst Consortia members. This focus has been achieved by:

Building relationships

The three Consortia have worked hard to build and sustain effective working relationships between Consortium members. Consortium members interviewed emphasised the significance of this and define it as a fundamental plank of their success. As one PHN manager said on interview "I'd say it is about relationships, relationships, relationships. You need to prioritise spending time with people, connect with them in a genuine way. The absolutely highest priority is to develop trust and foster and grow environments that foster and grow trust."

Leading with values

Leading with values is exemplified by a range of work done by the three Consortia to articulate and implement service delivery models that are grounded in values. Two examples of such service delivery models are included in Section 4.5.3. One interviewee contrasted different collaborative processes she has been involved in as either leading with a focus on dollars or on values, characterising her participation in one of the Brisbane North Consortia as the latter. She went on to describe the Consortium as making choices based on the best outcomes for the region and for consumers and hence as being firmly values-based.

Building leadership capability

Using in-house and external training and professional development opportunities to foster leadership capability and facilitate access to new ideas is one of the strategies we have used to engage Consortia members, to sustain their effort and to build their capability. Selected workshops and conferences as well as projects engaging external experts who bring fresh ideas and new expertise to the Consortia have contributed to this and have served to focus on high quality service delivery as well as to keep partners connected and engaged. Consortia members describe an environment that encourages partners to show leadership and to work on new ideas as well as professional development opportunities that result in a common language about ideas and frameworks that shape the Consortia's work.

In research undertaken for this Toolkit Consortium members shared many reflections on leadership and relationship building. A selection of these are included below.

What Consortium members said about leadership and relationship building

> "I think…the real underpinning has been the relationships, the ability to just really engage and really have generative dialogue with a higher level. It will go down in my career as one of those benchmark opportunities."

> "Working relationships - they are warm and productive and based in trust. There is enough trust that things can be raised. Not hard to raise difficult content. The more difficult thing is to get partners to challenge each other."

> "I was really new into a newly created role, new into PiR. Obviously, it evolved over time in those meetings but I think for me, my words would be energetic, professionally robust, focused on the bigger issue. I absolutely enjoyed coming to the meetings because, not only were you giving of yourself, your background and your knowledge, I certainly gained so much in terms of my own learning. Absolute compliments now and in the past, in terms of the backbone…. the comparative service and skill that this PHN brings forward is just exceptional."

> "The people in the room have an extraordinary amount of experience and the level of sharing is fantastic."

> "It takes time to build relationships; to build process and to build joint understanding. You can get outcomes from individualised contracts but we [PHN] know there are other results that happen outside these contracts as a result of this way of working. It's not always possible to capture and evaluate that but we know this occurs. This is a very developmental approach. Other approaches are practical but this is also philosophical - people need to sign on."

> "It was really good to see all the CEOs around the table. I thought, this is for real."

> "I really welcome the partnership and the approach because there are good ideas and perspectives. The great thing for me is that there are lots of providers coming in with new ideas for services. I think it is fantastic. Learning and communication and information exchange occurs."

> "You can have good governance and tick all the boxes and things don't change. But I think the values driven approach has meant that the partnership has continued to broaden and deepen and bring other parties on board."

In Section 4.5.2 we provide further illustrations of relationship and partnership building through practice examples from both healthy@home and PiR.

4.2 Connecting strategy and operations

An important aspect of our approach to collaboration has been to ensure that strategy drives operations and that, conversely, operations informs strategy. We have worked to ensure a connected and balanced focus on strategy as outlined below:

- We have established a two-layer governance structure for each Consortium, with one layer of this structure engaging senior management from partnering organisations and focusing on strategy and performance. The second layer engages staff from partnering organisations who are operational supervisors and focuses on operational service delivery and on ensuring that clients are receiving high quality services.
- The Consortia ensure that their governance meetings and agendas have a good balance of strategy and operational agenda items.
- Governance structures for the Consortia base decision making and strategy on good use of operational data.
- We use feedback on operational service delivery to provide informed advice on broader policy directions. For example, in RAS the PHN has participated in a national advisory

group for community aged care and direct feedback from service delivery has allowed us to provide advice on how the reforms are impacting consumers through this group.

- Undertaking work on both strategy and operations as part of the backbone agency's resourcing role has served to effectively balance strategy and operations. For example, as a backbone agency we have led strategic work on planning; influencing national policy; business development strategies and evaluation. We have also led operational work on operating policies, procedures and resources and IT systems to support service delivery.

The importance of balancing strategy and operations was illustrated in research undertaken for this Toolkit. When research participants were asked to indicate what they saw as the achievements of the Consortia, they included both strategic and operational examples. A selection of these are included in the following table.

4.3 Tools and processes

Part of our role as backbone agency for the three Consortia has been to ensure that tools and processes to enable and support service delivery have been available to partnering agencies. We list some of these tools and processes as examples below.

Consortium	Tools and processes to support service delivery
Brisbane North PiR Consortium	• A well-articulated and cohesive service delivery model with a common approach and processes enables partners to deliver PiR consistently across partnering agencies and the region. A summary of PiR's service delivery model is provided as a practice example in Section 4.5.3. • Model position descriptions for staff have been developed and joint recruitment strategies utilised. • A Consumer Information and Management System (CIMS) is used as a common IT platform for partnering agencies hosting PiR staff. • A reporting system, QlikView, that allows partnering agencies direct access to demographic, consumer and performance data has been established. See Section 5.4.1. for an illustration of QlikView. • The North Brisbane PiR Resource Kit, a comprehensive guide for the Consortium's PiR team, helps shape PiR's cohesive service delivery model. • A two-layer governance structure is in place.
healthy@home	• Business rules outlining roles and process for aspects of healthy@home's work have been developed. • CHSP Consortium Quality Compliance System outlines a quality framework and quality system for healthy@home as well as compliance arrangements against the required standards. • A two-layer governance structure is in place.
RAS Consortium	• A service delivery model that describes the operation of RAS and how it links to MAC, the national access arrangement for older people seeking services, has been articulated. • Model position descriptions have been developed for assessment staff. • Standard Operating Procedures that outline the RAS model, the consumer process, policies and business processes guide service delivery. • An IT platform that allows for data collection across partnering agencies has been established. • A two-layer governance structure is in place.

4.4 Navigating change

All three of the Consortia have needed to navigate substantial change both to the broader setting in which they operate and to their own structures and operating approaches. PiR has needed to steer its way through national work determining how the program must change in the advent of NDIS. healthy@home has navigated its way through both national community aged care reforms and, as part of this, the transition of HACC to CHSP. The RAS Consortium commenced operation in the context of the same national community aged care reforms and has also had to deliver services using newly designed national business processes for older people accessing community care. Internal changes have included changes to membership; to chairing arrangements and to funding streams. Overall, the maxim that 'change is the only constant' resonates for all three Consortia. Given this context, agility in navigating these changes successfully has proved to be critical to success for all three Consortia.

Consortium members shared reflections on their changing setting and the Consortia's agility in dealing with this in research undertaken for the Toolkit. Some of their reflections are provided below.

What Consortium members said about change

> "We are getting sharper and sharper. We're in a hard time dealing with all the different changes. This is what we're being responsive to, what is happening out in the sector. And working out how can we best respond to our consumers in terms of delivery of services within this model. It's really about looking at what's out there, what's our core business, about assisting people in the community to stay in the community."

> "We are still concerned about the future in the next couple of years but I'm really hopeful that the Consortium can find a different shared purpose and really look at those higher level objectives."

> "I think that it is really interesting that we're trying to figure out what are those next steps and bits …we are trying to make sure that we deliver on what we've already got but what does it mean in a changing environment? So for me it's lots of open questions again because I'm not quite sure what that looks like but I think that we've got some good stories to be able to share."

> "What I really note now is how fluid and how easy we sit in the grey and the uncertain. It really is now again a time of what does the future look like.
>
> I think my reflection is that our capacity to sit in the space collectively in the room is because of the relationships that have been built and the trust that has been held really, really well."

4.5 PRACTICE EXAMPLES AND RESOURCES

4.5.1 Consortia in aged care: A framework for success

The document below outlines a Framework for success for our aged care Consortia. The Framework utilises aspects of the collective impact approach to support and enhance its operation as well as to establish indicators used to measure the success of Brisbane North PHN as a lead or backbone agency.

Consortia in aged care

A framework for success

phn BRISBANE NORTH

An Australian Government Initiative

A consortium is an organisation of several businesses joining together as a group for a shared purpose[1].

While consortia can take various forms, Brisbane North PHN has adopted a Lead Partner/Supply Chain model to deliver its contracts with the Australian Government Department of Health for the Commonwealth Home Support Program and its Regional Assessment Service.

The Lead Partner/Supply Chain model involves more than just the sub-contracting of services and also includes a focus on collaboration to achieve service and system improvement.

Collective Impact Framework

Key features of a Collective Impact Framework include a centralised infrastructure approach and a backbone organisation, which has dedicated staff whose function is to help participating organisations shift from acting alone to acting in concert.

The Collective Impact Framework requires five key elements for success.

Brisbane North PHN performs the role of the backbone organisation modelled on the six functions as defined by the Collective Impact Framework table below.

Backbone effectiveness: 27 indicators

Guide vision and strategy	• Partners accurately describe the common agenda • Partners publically discuss/advocate for common agenda goals • Partners' individual work is increasingly aligned with common agenda • Board members and key leaders increasingly look to backbone organisation for initiative support, strategic guidence and leadership
Support aligned activities	• Partners articulate their role in the initiative • Relevant stakeholders and engaged in the initiative • Partners communicate and coordinate efforts regularly, with, and independently of, backbone • Partners report increasing levels of trust with one another • Partners increase scope/type of collaborative work • Partners improve quality of their work • Partners improve efficienty of their work • Partners feel supported and recognised in their work
Establish shared measurement practices	• Shared data system is in development • Partners understand the value of shared data • Partners have robust/shared data capacity • Partners make decisions based on data • Partners utilise data in a meaningful way
Build public will	• Community members are increasingly aware of the issue(s) • Community members express support for the initiative • Community members feel empowered to engage in the issue(s) • Community members increasingly take action
Advance policy	• Target audience (e.g. influencers and policymakers) is increasingly aware of the initiative • Target audiences advocate for changes to the system aligned with initiative goals • Public policy is increasingly aligned wtih initaitive goals
Mobilise funding	• Funders are asking non-profits to align to initiative goals • Funders are redirecting funds to support initiative goals • New resources from public and private sources are being contributed to partners and initaitives

Adapted from FSG and Greater Cincinnati Foundation

Partners 4 Health Ltd (ABN 55 150 102 257), trading as Brisbane North PHN.
Brisbane North PHN gratefully acknowledges the financial and other support from the Australian Government Department of Health.

4.5.2 Partnership survey snapshots: PiR and healthy@home

The Partnerships analysis tool

Both Brisbane North PiR and the healthy@home Consortia have used The Partnerships analysis tool (the Partnerships Tool) to assess how Consortium partnerships are travelling.[16] We include illustrations drawn from surveys conducted for both Consortia as a practice example to show how such data may be used to assess and strengthen partnerships. The surveys conducted using the Partnerships Tool asked survey participants questions about the following topics:

1. Determining the need for the partnership.
2. Choosing partners.
3. Making sure partnerships work.
4. Planning collaborative action.
5. Implementing collaborative action.
6. Minimising barriers to partnerships.
7. Reflecting on and continuing the partnership.

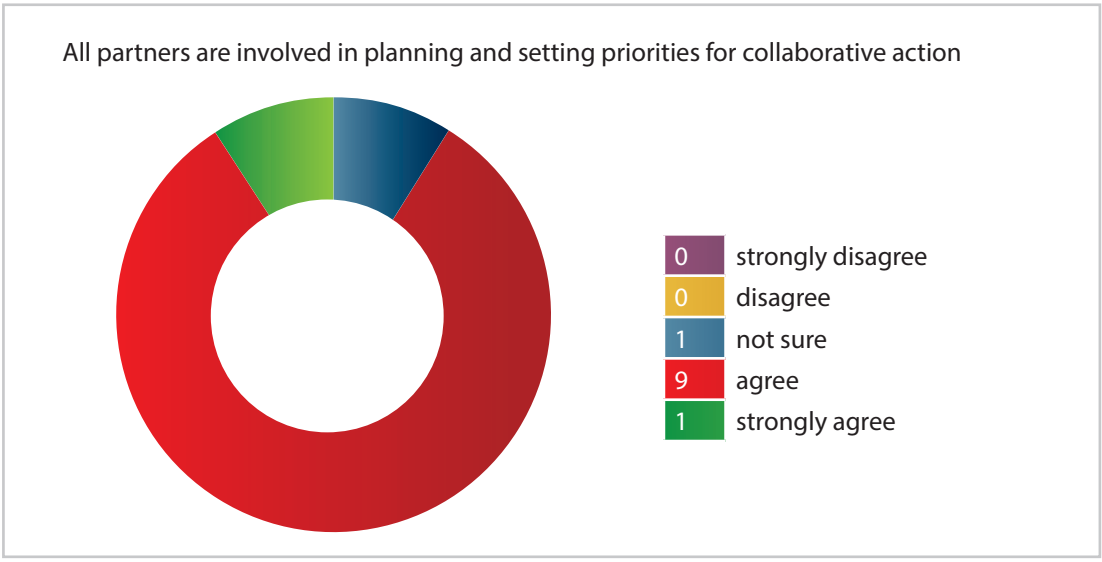
Respondents were asked to rate 35 statements about the partnership on a scale ranging from strongly disagree through to strongly agree. We provide two snapshots below to illustrate how we use partnership survey results to better understand and guide collaborative action.

Brisbane North PiR – snapshot

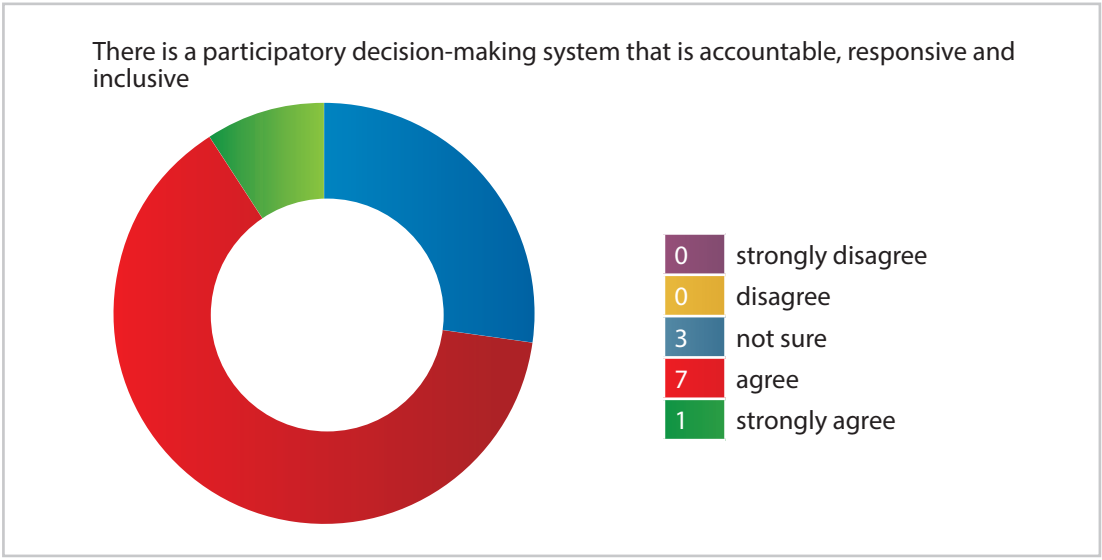
In April 2013, the Partnerships Tool was used as the basis of an on-line, confidential survey of 14 members of Brisbane North PiR's Consortium Management Committee (CMC). This survey was conducted just as advice had been received that the Consortium had been funded for PiR. The partnership had been in place for some months and considerable development work had occurred but there was still much work to be done on implementing the PiR model that had been designed.

Of the 14 CMC members surveyed, 11 responded. Partners were asked to rate the degree to which they were involved in planning and setting priorities for collaborative action with 10 of the 11 respondents agreeing or strongly agreeing that partners were involved in this.

16 Surveys undertaken of Consortia members are based on based on the Victorian Health Promotion Foundation's The partnerships analysis tool, Melbourne. 2011.



Survey respondents were also asked whether they were tasked with communicating and promoting the partnership in their own organisations or networks, with all 11 agreeing or strongly agreeing that this was the case. When asked whether some partners have roles that cross traditional boundaries between agencies, nine agreed and two were unsure. Seven out of 10 respondents indicated that lines of communication, roles and expectations were clear with four respondents unsure about this. Respondents were also asked to rate participatory decision-making and whether it was accountable, responsive and inclusive. Eight out of 11 respondents agreed or strongly agreed that such a decision making system was in place, with three respondents unsure about this.



healthy@home—snapshot

In October 2014, a confidential, on-line survey was conducted with healthy@home Consortium's HMG using questions drawn from the Partnerships Tool. 15 survey responses were received from the 23 HMG members surveyed. This survey was conducted after establishment of the Consortium, once initial operational pressures had eased somewhat, and Consortium members turned to further work on developing their partnership. An extract from the report on survey results is provided in the following table and features a summary of results from three of the seven survey topics: implementing collaborative action; minimising partnership barriers and reflecting on and continuing the partnership. As a further illustration, we include areas for continued development drawn from the survey report as well

as the overall rating gained through using the Partnerships Tool.

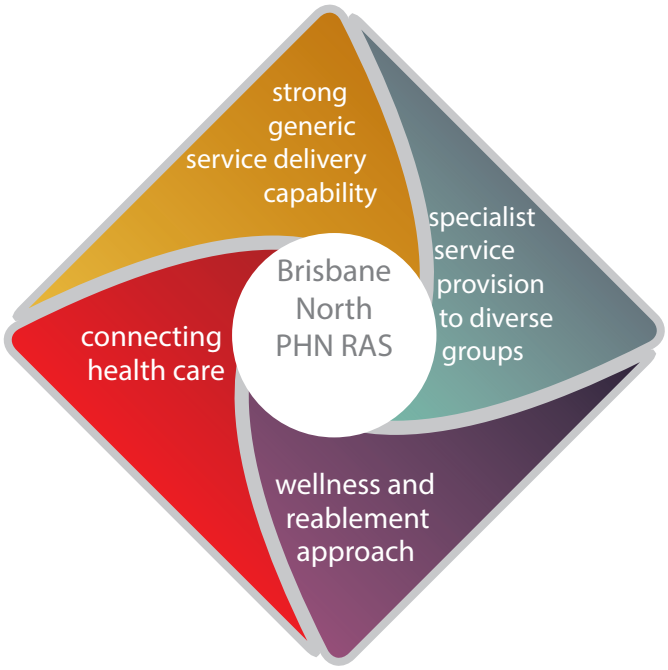
healthy@home – results of October 2014 Partnership Survey		
Partnership dimensions	Results	Areas for further development
Implementing collaborative action.	• Common, standardised processes across agencies is a potential area for future development with eight respondents disagreeing these were present, three unsure and only four agreeing. • Investment of time, personnel or other resources in the Consortium is a clear area of strength, with 14 out of 15 respondents agreeing this occurs. • Only eight respondents agreed that collaborative action and partnering is rewarded by their management, with six respondents unsure whether it is and one disagreeing. • 12 out of 15 respondents agreed that the Consortium's collaboration adds value for clients. • Nine respondents agreed there were opportunities for regular, informal contact across partnering agencies.	Common, standardised processes across agencies.
Minimising the barriers to partnerships.	• Opinion was mixed about whether differences in organisational priorities, goals and tasks have been addressed when necessary with three respondents disagreeing, seven unsure and five agreeing. • Respondents were very clear that a core group of skilled and committed staff have been involved in the Consortium with 14 out of 15 agreeing that this is the case. • Respondents' views about whether there are formal structures for sharing information and resolving demarcation disputes differed with only four agreeing this was the case and five disagreeing. • Respondents rated informal mechanisms for doing this more positively with none agreeing these were in place and only three disagreeing. • Ten respondents agreed there were strategies in place for ensuring alternative views are expressed, with four respondents unsure about this and one disagreeing.	Addressing differences in organisational priorities, goals and tasks when necessary. Putting formal structures for information sharing and dispute resolution.

healthy@home – results of October 2014 Partnership Survey		
Partnership dimensions	Results	Areas for further development
Reflecting on and continuing the partnership.	• Only eight respondents thought there were processes in place for recognising and rewarding collective achievements and individual achievements. • Respondents rated the Consortium's ability to demonstrate or document its work more positively with 11 respondents agreeing or strongly agreeing that this can be done. • An extremely positive view was expressed on continuation of the partnership with 14 out of 15 respondents agreeing or strongly agreeing that there is a need for, and commitment to, a continued partnership. • 11 respondents agreed there are resources available to continue the partnership. • Eight respondents disagreed there is a way for reviewing the Consortium's current membership with five unsure about this and only two agreeing there is an identified way of doing this.	Mechanism for reviewing Consortium's membership. Rewarding and recognising collective effort and individual achievement.
Overall results.	• Respondents' views resulted in an aggregate score of 124.68. VicHealth's scoring scale places this at the top end of the score range indicating that the partnership is moving in the right direction but will need more attention if it is to continue to be successful.	Well done Consortium members. Keep up the good partnership work!

4.5.3 Service delivery models for RAS and PiR

We include here as practice examples, a summary of two quite different service delivery models—those for RAS and PiR.

Practice example one: RAS service delivery model



Our service delivery model

Our model for delivery of assessment services is part of MAC[17] and so operates within an end to end business process allowing consumer-focused and integrated access by older people to aged care services. The service delivery model for RAS is summarised below.

Our model focuses on quality service delivery and alignment with DSS's business processes and is underpinned by:

- the PHN's role in connecting healthcare and our vision for integrated healthcare
- a wellness and re-ablement approach that connects older people to healthcare and supports them to live healthy and independent lives
- strong generic service delivery capability enabling us to offer high volume services to a range of older people
- specific capacity to provide assessment services to older people from diverse population groups.

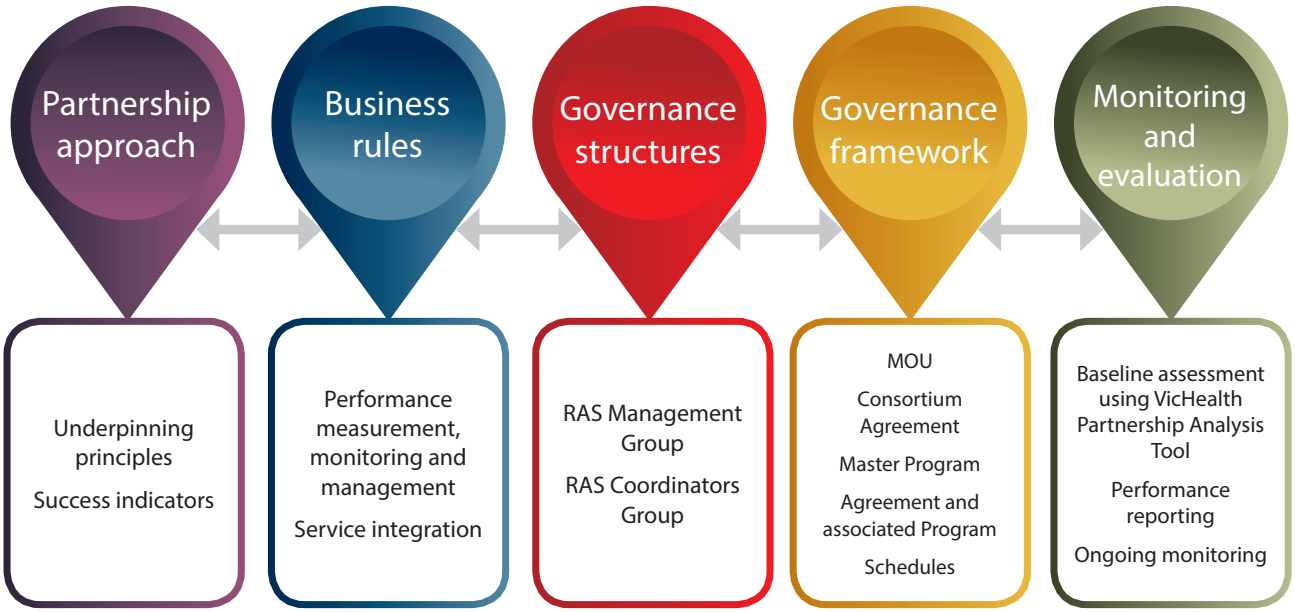
17 MAC refers to the new approach to community aged care implemented by the Australian Government. You can find out more at http://www.myagedcare.gov.au/

Our partnership model

Our partnership model describes the commitment and approach to partnering by the RAS Consortium. Our model is underpinned by the following principles:

- delivery of RAS services will centre on the needs of people requiring either ongoing or low intensity services or episodic short term higher intensity services in the community
- partners will actively foster a culture of quality practice in the delivery of RAS services
- partners will value and respect each other
- partners will work collaboratively as part of the Consortium
- partners will actively participate in, and contribute to, the Consortium
- partners will communicate openly, frankly and robustly
- partners will work constructively with one another to resolve problems
- partners will differentiate between their individual or organisational interests and those of the Consortium and be open about these differences when this is necessary to the effective operation of the Consortium
- partners will disclose any potential conflicts of interest that impact on the Consortium's work
- as far as possible, partners will ensure continuity of membership and regular attendance at relevant meetings.

The following diagram summarises the model we use to ensure our partnership is strong and well-governed.



Practice example two: Brisbane North PiR service delivery model

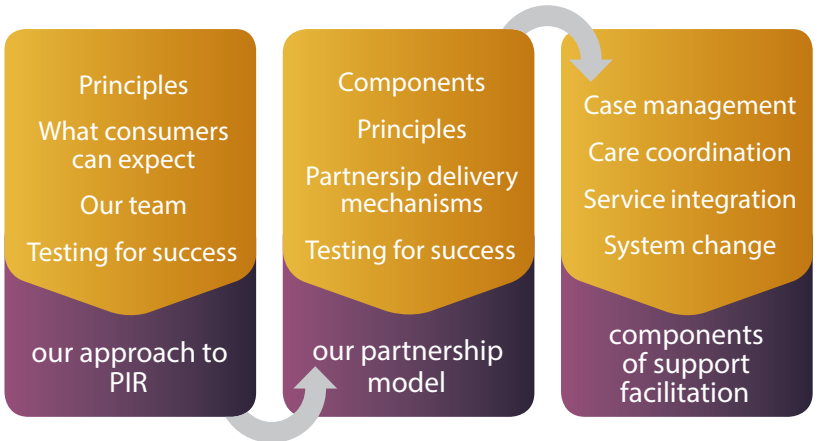
What we do

The components of the service delivery model for Brisbane North PiR were developed as part of implementation planning for PiR and are set out in the following table. Some adjustments have been made to reflect changes since PiR was first implemented.

Components of service delivery model for Brisbane North PiR	
Lead agency	The PHN is the lead agency for Brisbane North PiR.
Support facilitation model	Eight agencies host support facilitation teams. Each of these agencies is responsible for specific geographic areas within North Brisbane and Moreton Bay, as well as offering services across the region to respond effectively to consumer demand and enable efficient use of resources.
Flexible funding	Flexible funding is available to fund individual consumer services and supports.
Sector collaboration	Sector collaboration is about influencing longer term changes to legislation, policy and how services operate to improve outcomes for PiR consumers. It is central to PiR's objectives and responsibility for it is shared across the Consortium.
Quality practice function	The quality practice function is located in the PHN and will ensure that high quality practice models, methods and tools are applied in PiR for best outcomes for PiR consumers. The PHN will do this work in partnership with Consortium agencies.
Regional collaboration mechanisms	We will build inter-sectoral linkages and facilitate strong engagement across the service system in North Brisbane and Moreton Bay. Partnership agreements, MOUs and joint work will support collaboration.
Governance and performance management	The Consortium is made up of representation from 11 partnering organisations as well as consumer and carer representatives. The CMC includes executive representation from each partnering agency as well as consumer and carer representatives. A performance management model operates through a partnership agreement between Consortium members and performance based contracts between the PHN and each Consortium member receiving funding.

How we do it

Delivery of PiR in North Brisbane and Moreton Bay is underpinned by three important frameworks which together help us understand what we are delivering and how. An overview of these frameworks is provided below.



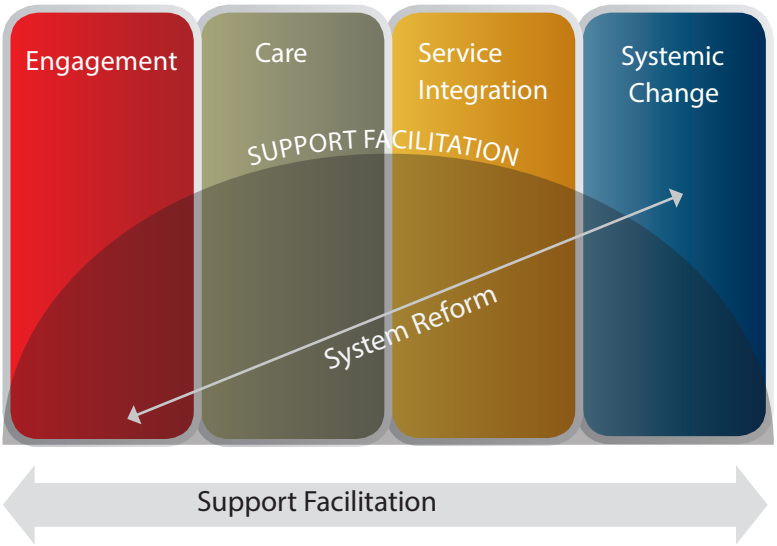
Our approach to PiR

The framework underpins how we work in PiR. It establishes overarching principles for how we do our work and describes what consumers using PiR can expect and what is expected of the PiR team. It also describes what successful delivery should look like. It can be used to shape and drive what we do and to help us reflect on our work and its results.

Our principles …	We are recovery oriented. We offer assistance to those who need it most. We work to improve how the system works for consumers and carers. We don't replace other services, we work alongside them.
Consumers can expect us to …	Respect their values, beliefs and perspectives. Utilise their preferred methods of communication. Assist with finding ways to improve their quality of life. Involve them and their nominated carers, family and friends in planning and decision making.
Our team …	Is committed to a joint vision and plan for PiR. Creates and champions change. Finds creative solutions. Bases action of evidence and then reflects on outcomes. Welcomes people with a lived experience and carers to work with us. Works in partnership with other service providers.
We will know we are doing well when …	PIR has a good name and consumers recommend us. We are working with more organisations and across sectors. We see systems change for the better. Consumer and carer geedback results in changes to how we work. We have performance indicators in place and we achieve them.

Components of support facilitation

We have already identified the objective of PiR as being to work to achieve better results for consumers through improvement and change to the service system. The following framework identifies the components of support facilitation that can be used to do this. The framework can be used as a tool to understand support facilitation work; to identify strategies for tackling a consumer or service system issue; to reflect on progress; and in supervision.



5. Focusing on the long game

Together with our Consortium partners we have worked hard to focus on the 'long game' by creating and sustaining a performance oriented culture; by focusing on quality and by learning as we go. In this Section we explore how we have done this.

5.1 Building a performance oriented culture

We have worked with our partners to build a performance oriented culture as outlined in:

- We have ensured that a thorough approach to data collection and analysis is in place.
- Effective performance reporting has been used to monitor, adjust and review service delivery and to create 'shared measurement systems.'[18]
- Establishing IT systems that support data collection and analysis and ensuring Consortium partners have good access to data and to these IT systems, has helped to build a performance-oriented culture. For example, in PiR we use a data collection and analysis system, QlikView, that gives our partners the ability to examine and manipulate data and so to understand and assess consumer outcomes and organisational performance. In Section 5.4.1 we provide sample screenshots from QlikView that illustrate the data it makes available.
- Using performance data to assist resource allocation decisions has served to improve the outcomes we achieve. In interviews undertaken as part of research for this Toolkit, a number of Consortium members described how resource allocation decisions have been based on robust evidence, good data and consumer outcomes.
- We have created a culture that focuses on 'the long game.' This means focusing on

18 Op cit, Pages 39 and 40, Kania and Kramer, Collective Impact.

consumer and carer outcomes achieved with the support of our services and on how we can strengthen these outcomes by improving our services.

In research for this Toolkit, Consortium members shared their perspectives on creating a performance oriented culture. We include some of these below.

What Consortium members said about a performance oriented culture

> "The power of self-regulation is critical. Sharing of data and getting people to work off data has been critical to change and I didn't expect this. I wouldn't have previously put an emphasis on this."

> "Data that measures performance and business tools such as a shared IT system is critical. Data is shared with Consortium members and this helps drive change."

> "Sometimes it's difficult to make funding decisions. When we bring people back to what's best for the consumer they mostly make unselfish decisions based on what people need."

> "There is the example of one agency who hadn't met all of their targets and this is brought back to the Consortium and another organisation uses the money for service delivery. We keep money regionally by moving it around. We are then more likely to get the money out the door."

> "We…put this [additional funding] on the table at a meeting and Consortium members agreed after two hours where the money should be allocated. I think this is remarkable and demonstrates the strength of it."

> "Very strong. Links to data, strong systems, good quality processes, Good follow up. Good circle of continuous improvement and commitment from lead agency and their staff and partner commitment."

Consortium members also reflected on the need to further improve shared measurement systems and on what is required to realise this improvement.

What Consortium members said about shared measurement systems

> "Current work is about this and is really interesting. It's about client experience and aged care. Exciting stuff. We are starting to get shared measurement tools for consumer satisfaction. At the moment we are delivering – then we are taking the next step to measure."

> "[We use] CANSAS[1] and some tools in PiR, where we are measuring existing vulnerabilities and looking at the work we do. It's good but we could probably look at getting some more detailed analysis of the effect of program. That work is starting. We need to do significant work together given the focus on NDIS."

> "Interesting. If we are talking about direct service delivery, there is probably some work that could do done there in terms of how consistent we all are. Quality of care is still measured individually and sharing of that information, hopefully that is open and transparent, and people can share improvements needed. In terms of the bigger picture and of KPIs – we are ticking the boxes tremendously so we are able to measure that."

> "I don't think it's a developed area. This is certainly a growing area and I know people are keen to see new CHSP measures. I think this is something we need to come together about collaboratively. There is work being done on outcome measures and hopefully we can use this universally across the Consortium. We know all our clients are complex. They have physical, social and intellectual needs. We need to find a tool in terms of all these that measures holistically."

> "Highly effective, despite the challenges of developing systems. This area is a real strength of the PHN. Still early days and there is more to do. It's starting to happen."

Table endnote

1 Camberwell Assessment of Need Short Appraisal Schedule (CANSAS) is an assessment tool used in PiR.

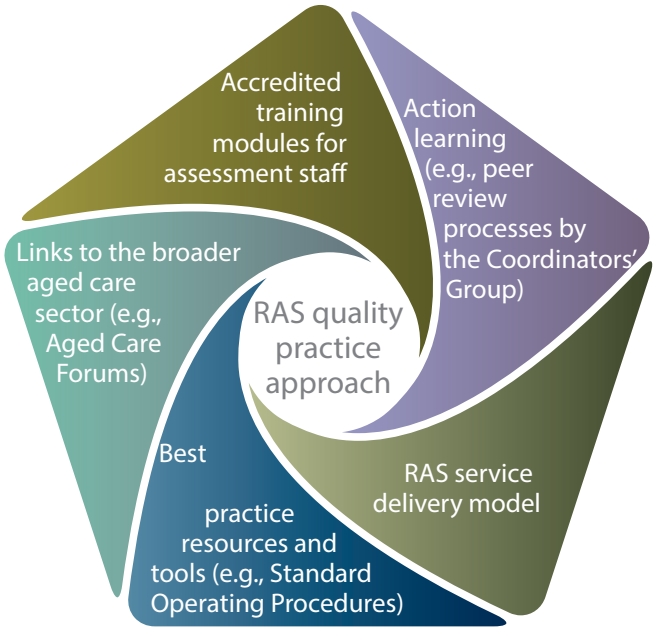
5.2 Focusing on quality

All three of our Consortia task us as backbone organisation with leading quality practice. This is done in close collaboration with partnering organisations and consumer and carer representatives. We outline the components of this quality practice role below:

Designing and implementing service delivery models

At the heart of our quality practice approach are well-articulated service delivery models that are underpinned by:

- the PHN's role in coordination of healthcare and in ensuring people receive the right care in the right place at the right time as well as our vision for integrated healthcare
- philosophical approaches that guide how we work with consumers and carers and are specific to each service such as PiR's recovery approach and the wellness approach adopted by CHSP and RAS
- our specific commitment to consumers and carers outlining what they can expect from service delivery and complementing and operationalising broader philosophical approaches
- success indicators that describe how we want service delivery to look, shape our direction and help us review how we are going.



Best practice resources and tools

Developing and implementing quality resources and tools has been a feature of our quality practice work. Examples include the North Brisbane Partners in Recovery Resource Kit and RAS's Standard Operating Procedures.

Training and practice learning

These are critical components of our quality practice approach and partners have participated in a range of training and professional development opportunities to facilitate practice improvement. Examples are outlined in Section 5.4.4 in our Refresh and review timeline. A further illustration is provided by completion of mandatory training units by RAS assessment staff, a requirement for delivering assessment services. We discuss practice learning strategies in Section 5.3.

IT systems to support service delivery

These are an important aspect of our quality practice approach. For example, PiR is supported by CIMS, a system that enables secure management of consumer information with system access controls that incorporate consent and privacy arrangements; specified business processes to ensure consistent service delivery across partnering agencies; workflow management; and data collection to allow reporting and performance measurement and monitoring.

5.3 Learning as we go

In Section 2.2 we describe our approach to collaboration and identify 'learning as we go' as fundamental to our collaborative work. Learning as we go has allowed us to build our collaborative skills and improve our approach over time. We have actively reflected on our early collaborative work and so refined and strengthened later work. Below we explore three aspects of 'learning as we go' that have been important for us.

Practice learning strategies

Our approach to practice learning is demonstrated well by our Consortia's second layer governance structures. These governance structures are tasked with service improvement and so are positioned well to realise opportunities for practice learning including peer learning processes. Examples of this include Learning Circles in PiR (see Section 5.4.3 for sample Terms of Reference for a PiR Learning Circle); staff exchanges as part of induction for new service delivery staff; and more structured practice training opportunities on a variety of topics such as guardianship and substitute decision making, mental health issues for older people and wellness. A further example is provided by practice learnings identified through the local PiR evaluation. As the evaluation unfolded we used consumer and carer feedback in practical ways to improve our practice including by developing a complaints procedure leaflet and an information kit outlining what consumers and carers can expect from PiR.

Ways to review and refresh

Right from the get go Consortium partners have worked hard to design and deliver services for consumers. In this busy environment, we have made sure that we have created space for Consortium partners to review progress and refresh our collaborative approach. These 'refresh and review' opportunities have included:

- workshops that facilitate reflection on our services, on how our partnerships are going or on planning for the future
- professional development and training opportunities attended by all or some Consortia members
- surveys that assess partners' satisfaction with the PHN as backbone organisation or collect data on how Consortia partnerships are going
- surveys that ascertain consumer and carer service satisfaction (e.g., the RAS Client Satisfaction Survey Report provided as a practice example in Section 5.4.2) and forums that give consumers and carers the opportunity to provide feedback on the services they access
- meetings of our governance structures that balance operational business with work focusing on innovation and future business.

In Section 5.4.4 we provide a Refresh and review timeline that describes some of the events

that have helped us to stay fresh and re-evaluate and re-assess our approach.

A focus on evaluation

A robust focus on local evaluation and particpation in program-wide evaluation opportunities have also been part of our learning as we go approach. Our evaluation work has included:

- participation in the national PiR evaluation commissioned by the Australian Government's Department of Health
- development of a local evaluation framework for PiR with well-articulated local evaluation elements (see Section 5.4.5 for an outline of these elements)
- engagement of consumers and carers as local evaluators for PiR with a focus on using independent peer-to-peer processes to seek authentic feedback from consumers and carers
- evaluations of PiR and healthy@home undertaken by QUT's Australian Centre for Health Services Innovation.

In the following table we provide an illustration of our evaluation work through a brief snapshot of QUT's evaluation of healthy@home's work.

Snapshot—Evaluation of the healthy@home model[1]	
What the evaluation looked at.	• consumer satisfaction • cost of service delivery • service provider opportunities
What the evaluators did.	• The evaluation was conducted between 2013 and 2015 with a progress report completed in October 2014 and a final report completed in October 2015. • The evaluators: – collected and analysed data – interviewed consumers and Consortium members – held consumer focus groups.
What we learnt from the evaluation.	• Consumers remained satisfied throughout the transition from the previous service delivery arrangements to the new Consortium arrangements. • The transition to the Consortium model dramatically reduced costs to the Australian Government. Efficiency gains arising from the transition were found to be close to 30%. These savings were partly attributed to the introduction of a client co-payment and partly to efficiencies realised under the Consortium model, which resulted in the Consortium far exceeding its delivery targets across all service types by 2014–15. • The evaluation emphasised the importance of the PHN's governance role within the Consortium and noted this was likely driving service improvements. The evaluation also found there was a need for this role to mature and develop over time. • Partners identified a range of benefits arising from joining the Consortium. These included networking and professional development opportunities, expansion of their consumer base, greater service flexibility and enhancement of their individual business model through collaboration with other providers. • Some challenges were also experienced by providers, including increased administrative and reporting burden. However, the report found these were at least in part offset by the beneficial role the PHN played in centrally handling contracts and funding allocations.
What we are proud of.	• Consumers are satisfied with our services. • We deliver more service outputs than we were originally funded for using the same funding allocation. • The PHN's work as the backbone organisation is going well. • Our partners see benefits in being part of healthy@home.

Table endnote

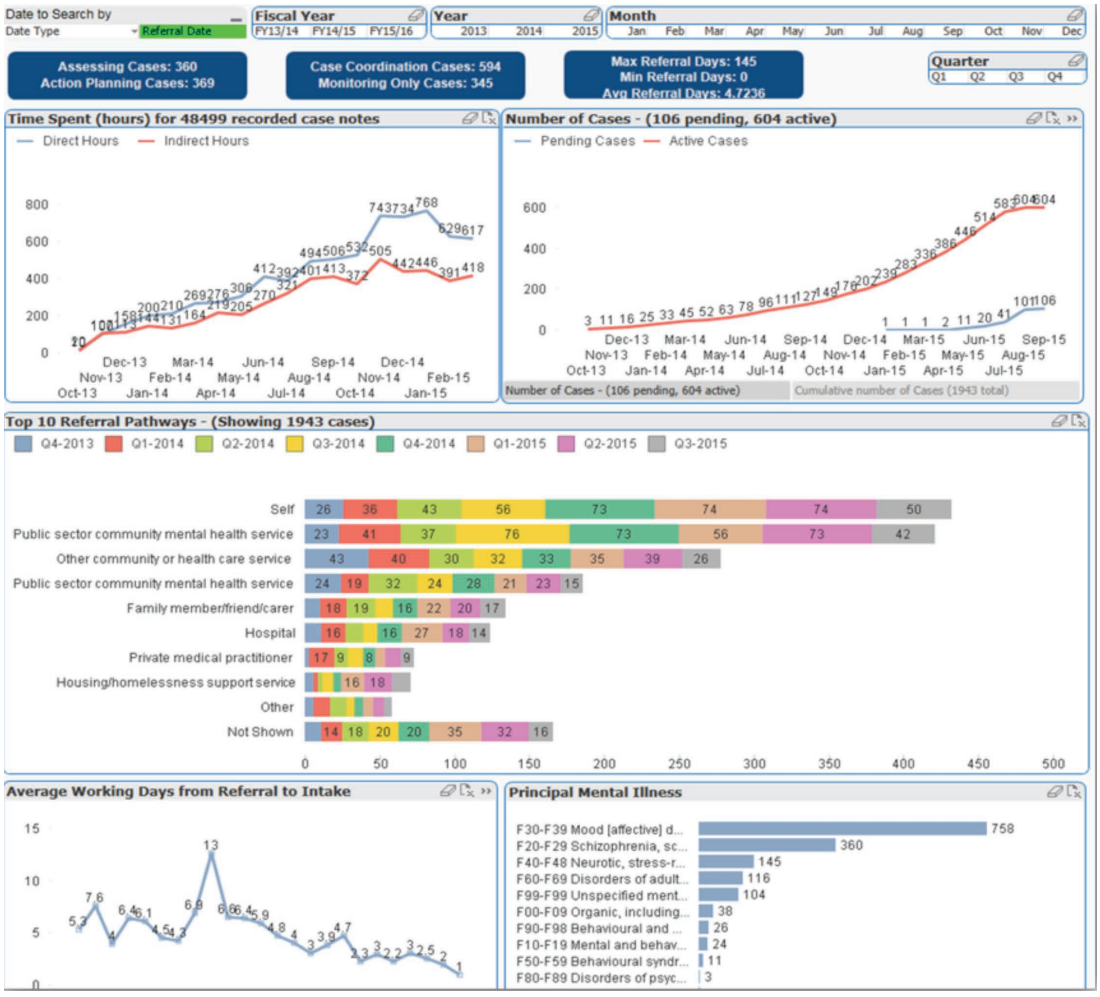
1 Op cit, McCreanor, Theroux and Graves, Evaluation of the Metro North Brisbane Medicare Local HACC Consortium

Model.

5.4 PRACTICE EXAMPLES AND RESOURCES

5.4.1 QlikView: PiR's reporting system

QlikView is the data reporting system used for Brisbane North PiR. Each partnering agency has access to QlikView and can use it to display a wide range of data allowing analysis of service delivery results or of de-identified information that shows consumer outcomes. To illustrate QlikView and the data it generates, two QlikView screenshots are provided below.

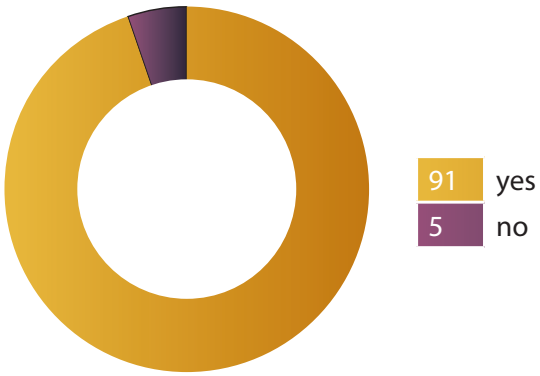



Date to Search by
Date Type
Referral Date
Fiscal Year
FY13/14 FY14/15 FY15/16
Year
2013 2014 2015
Month
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec
Quarter
Q1 Q2 Q3 Q4
Males: 847 (46%)
Females: 988 (54%)
All Clients: 1841
Indeterminate: 2 (0%)
Intersex: 3 (0%)
Not Stated: 4 (0%)
Aboriginal: 145 (8%)
Torres Strait Islander: 22 (1%)
Both: 17 (%)
Cumulative number of Clients
Client Age and Gender Breakdown
Males
Females
0 <= Age < 10
10 <= Age < 20
20 <= Age < 30
30 <= Age < 40
40 <= Age < 50
50 <= Age < 60
60 <= Age < 70
70 <= Age < 80
80 <= Age < 90
110 <= Age < 120
150 <= Age < 160
Employment Participation
Not applicable - Not in...
Not stated/inadequate...
Part-time
Full-time
Employment Participation
Employment Status
Highest Education Level
Not stated/inadequately de...
Senior Secondary Education
Junior Secondary Education
Certificate Level
Bachelor Degree Level
Advanced Diploma and Dip...
Primary Education
Postgraduate Degree Level
Graduate Diploma and Gra...
No Education
Other Education
Pre-primary Education
Highest Education Level
Education Participation
Carer Details
No carer
Not stated/Unknown
Informal carer
Formal carer
Top 10 Client Postcodes
4510
4006
4034
4019
4000
4020
4032
4500
4017
4053

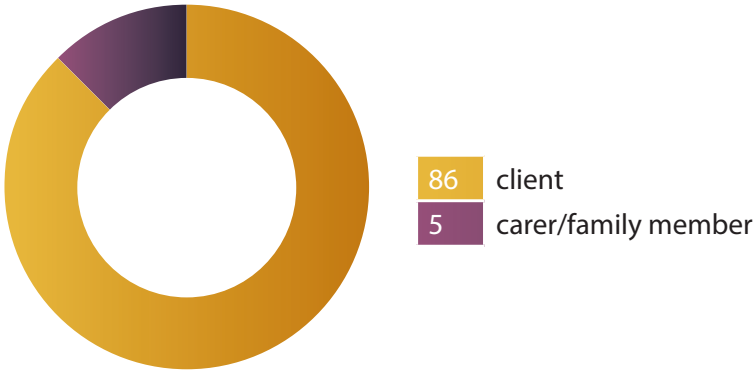
5.4.2 Sample RAS Client Satisfaction Report

We have included below the questions we use to assess client satisfaction in RAS, as well as results drawn from one of our survey reports as a practice example.

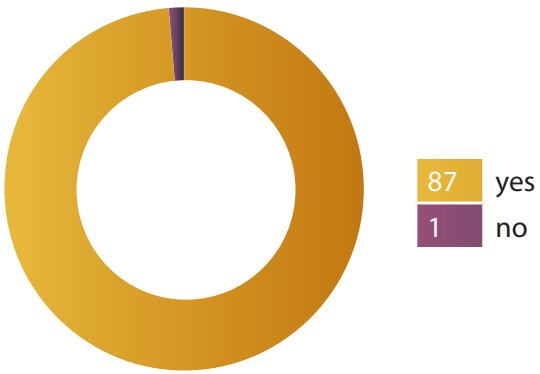
1. Overall, were you satisfied with your assessment?



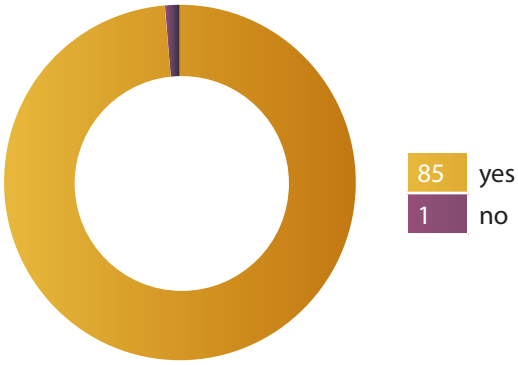
2. Is the person completing the survey the MAC client or their carer/family member?



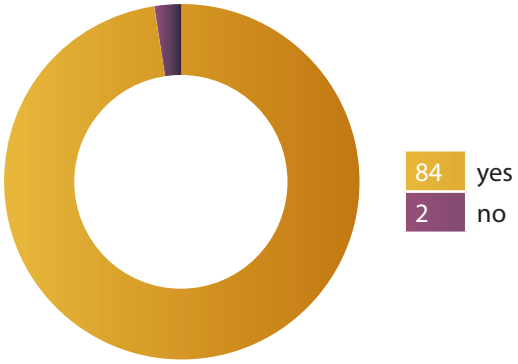
3. Did my assessor clearly explain the assessment process to me?



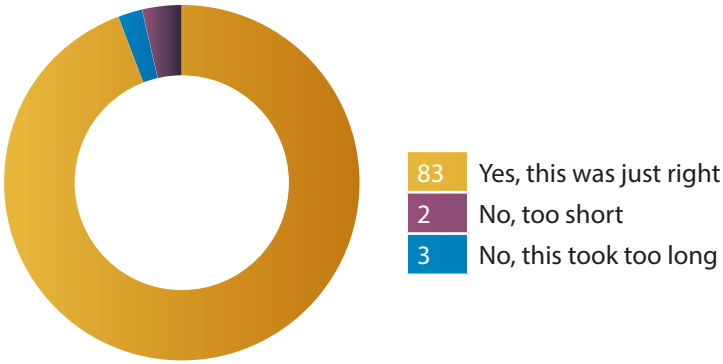
4. Was my assessor friendly and courteous?



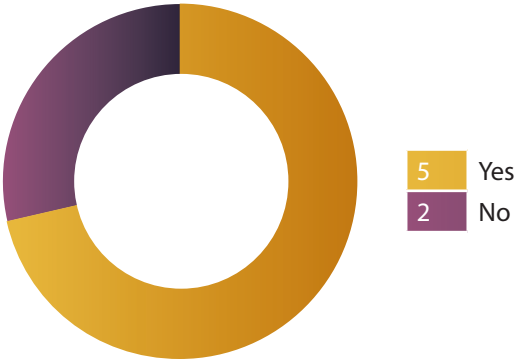
5. Did my assessor involve me in making decisions about my assessment?



6. Do you feel like your assessor spent the right amount of time with you to complete this assessment?



7. Would you like someone from our independent RAS team to contact you and discuss your feedback?



5.4.3 PiR Learning Circles

As part of its quality practice approach, PiR has established Learning Circles that enable staff to improve their practice and so achieve better results in their work with consumers. An extract from the Terms of Reference for one of these Learning Circles is provided below as a practice example.

NORTH BRISBANE PARTNERS IN RECOVERY

Learning Circle Three: Guiding Principles

MEMBERSHIP
The members of Learning Circle Three are: • Support Facilitators from partnering agencies • Quality Practice Lead, Brisbane North PHN • System Reform Lead, Brisbane North PHN.
MEETINGS
• Meetings are expected to be held on the third Thursday of every second month for one and a half hours in duration at a PHN office (either in Lutwyche or at North Lakes). • Each meeting will be facilitated by the PHN's Quality Practice Lead. • A record of the discussion topics, resources reviewed, key points, reflections, actions and adaptations at each meeting will be taken. The role of 'note taker' will be rotated among Circle members. • Notes taken by the note taker during the Learning Circle will be shared with others unless specified otherwise during the Learning Circle in which the notes were taken. Notes will be made available via the North Brisbane PiR website log on area. • Each meeting will have two or three discussion themes that can be linked back to support facilitation practice, particularly 'systems change'. Themes for successive meetings will be identified and collegially prioritised at the end of each meeting. • At the beginning of each meeting the facilitator will check to see if there are any other matters for discussion. The Group will then collegially agree how much time will be allocated to each discussion area. • Members will have the capacity to 'check in' with one another outside of the group about matters they have discussed during a meeting unless specified otherwise during the Learning Circle. • Approximately 10–15 minutes at the end of each meeting will be dedicated to 'checking out.'
RESPONSIBILITIES
1. Members will commit to attending all scheduled group meetings. 2. Members will expect: a supportive and non-judgement environment in which open and honest discussions can take place; confidentiality to be upheld during and after meetings; and discussions to be related to direct support facilitation practice. 3. Members acknowledge that there are variations between individual, team and catchment area based approaches.
AMENDMENTS
These Guiding Principles will be amended over time as the Learning Circle evolves. Amendments will be made after consultation and agreement by members.

5.4.4 Refresh and review timeline

The following timetable outlines examples of professional development opportunities that have been used by the Consortia to 'refresh and review'. A combination of internal events that use external experts such as facilitators (e.g., workshops) and external events (e.g., conferences attended by a small number of Consortium representatives) are included.

Refresh and review timeline		
All Consortia[1]		
What we did	When	What it was about
Collective Impact Conference.	February 2014	PiR and healthy@home Consortium members attended to gain an understanding of collective impact and apply it to their work.
Adaptive Leadership Training.	September 2014	Four days of training were delivered by Social Leadership Australia to develop the leadership capacity of Consortia members and the sector.
Workshop marking commencement of Consortium Toolkit Project.	March 2016	Workshop to identify Consortium members' perspectives on development of this Toolkit.
Collaboration for Impact Conference.	May 2016	The conference was attended by selected Consortium members and PHN staff.
PiR Consortium		
What we did	When	What it was about
Workshop on broader role in regional mental health.	August 2014	This workshop explored the Consortium's Management Committee taking a wider role in coordinating the mental health system in the region.
Inaugural workshop for 'Collaboration in MIND.'	June 2016	This workshop represented the first meeting of 'Collaboration in Mind', a new strategic coordination collaborative for mental health.
healthy@home		
What we did	When	What it was about
Inaugural Management Group Meeting.	April 2013	Establishment of Consortium's overarching governance arrangements.
Inaugural Coordinators Group meeting.	September 2013	Establishment of second tier of Consortium's governance arrangements.
Facilitated workshop with Coordinators Group.	March 2014	Development of Coordinators Group facilitated by external consultants.
Facilitated workshop with sub-set of healthy@home partners.	September 2015	Development of Aged Care Transitions Collaborative, a subset of healthy@home members, that successfully tendered for transition care funding.

Refresh and review timeline		
Facilitated workshop to develop the Allied Health Collaborative Project.	October 2015	To identify local needs and issues and establish a collaborative model for allied health providers.
Consortium Coordinators Group training – Understanding Quality Reviews.	November 2015	Professional development, team building and understanding of Home Care Common Standards.
Coordinator group training – Guardianship and Substitute Decision Making.	November 2015	Professional development, team building and improved understanding of decision making framework.
Workshop for development of Consortium's Strategic Plan and review of MOU.	December 2015	To undertake planning for future directions of the Consortium.
Consortium Coordinator Group training – Older Persons Mental Health Training.	April 2016	Professional development, team building and improved understanding of mental health issues impacting on the lives of older people.
Facilitated Coordinators Group Consultation Workshop.	May 2016	Team building and review of Terms of Reference.
Allied Health Collaborative Dinner.	June 2016	Build knowledge of the Collaborative in the sector and provide sector professional development
RAS Consortium		
Inaugural monthly RAS Assessor Information Sessions.	October 2015	Partnering organisations and other aged care organisations provided information to assessment staff about the services they provide.
RAS Assessor Wellness Workshop.	September 2016	A practical workshop held by Access Care Network Australia to upskill Assessors on how to embed wellness into their assessments and attended by Consortium managers, supervisors and assessment staff.

Table endnote

1 This refers to all Consortia that were established at the time the event occurred.

5.4.5 PiR's local evaluation elements

The PiR team, in conjunction with the Consortium, has developed local evaluation elements that outline the approach taken to conducting a local evaluation and incorporates national evaluation objectives along with associated outcomes, processes and structures. These are outlined below.

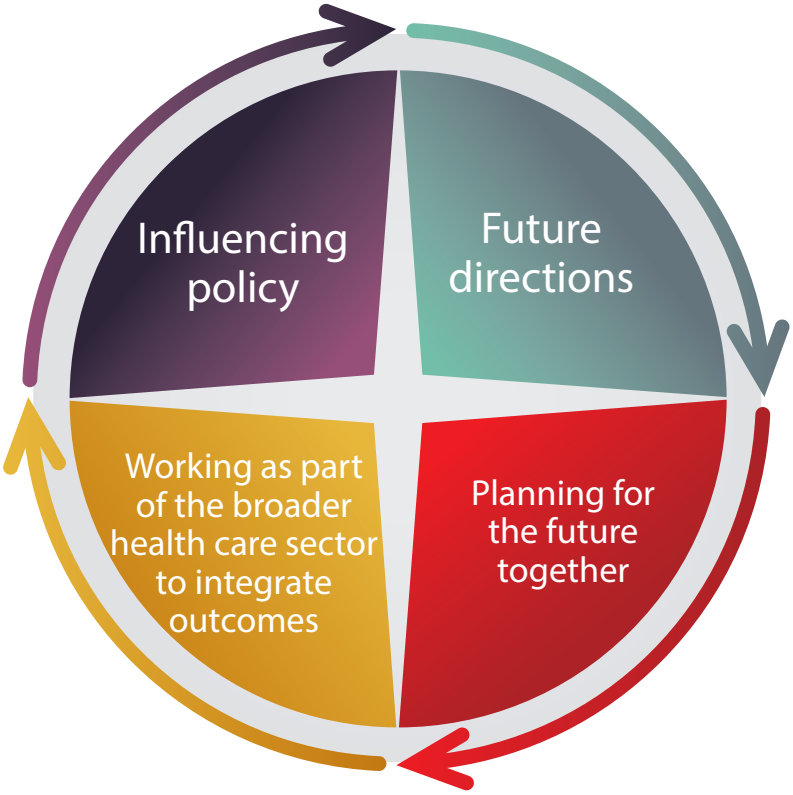
National PIR objectives	Localised PiR outcomes	Localised PiR processes	Localised PiR structures
Facilitating better coordination of clinical and other supports and services to deliver wrap around care individually tailored to the person's needs.	• PiR consumers and their families/carers have improved access to required services and supports. • PiR consumers and their families/carers receive integrated support from a range of required services and supports. • PiR consumers and their families/carers experience high quality community support services and service systems. • PiR consumers and their families/carers experience high quality care. • PiR consumers demonstrate improved well-being. • PiR consumers and their families/carers experience improved transitions from facility-based care to community based care.	• Partners in Recovery organisation (PiRO) is mapping services and reviewing needs in the region for PiR's target group. • PiRO is building relationships with consumers to understand the needs of PiR's target group. • PiRO facilitates the mechanisms to coordinate care and integrate services to deliver wrap-around care to PiR's target group. • PiRO utilises consumer and service data to adapt service provision to PiR's target group.	• Support facilitation model is in place. • PiRO staff are recruited and appropriate training and capacity building is provided as required.
Strengthening partnerships and building better links between clinical and community support organisations responsible for delivering services to PiR's target population.	• The level of coordination between clinical and community support providers is improved within the PiR network.	• PiRO supports building partnerships across service providers (both clinical and community) to engage in new and/or more effective coordination to better meet the needs of the regional PiR population.	• PiRO network is established. • PiRO partner organisations operate effectively as a consortium in the establishment and early implementation phases.

National PIR objectives	Localised PiR outcomes	Localised PiR processes	Localised PiR structures
Improving referral pathways that facilitate access to the range of services and supports needed by PiR's target group.	• PiR consumers, their families/carers and service providers demonstrate knowledge of available community supports, services and service systems. • PiR consumers and their families/carers receive integrated support from a range of required services and supports.[1] • PiR consumers and their families/carers demonstrate increased usage of appropriate community supports and services.	• PiRO facilitates the provision of information to consumers, carers, service providers and the community about service availability, access, integration and community supports. • PiRO facilitates the provision of services and supports to meet the recovery needs and goals of PiR consumers. • PiRO facilitates processes to match local services with the recovery needs and goals of PiR consumers.	• Referral, intake and assessment processes are developed and in place. • PiRO is accepting consumers in line with agreed inclusion criteria.
Promoting a community based recovery model to underpin clinical and community support services delivered to people experiencing severe and persistent mental illness with complex needs.	• PiR consumers and their families/carers are actively involved in recovery. • Consumers, service providers and the communities have a better understanding of the needs of people with severe and persistent mental illness. • PiRO demonstrates equitable outcomes for all PiR consumers.	• PiRO prioritises the lived experience and insights of people with severe and persistent mental illness and actively involves PiR consumers, and their carers, in developing, implementing and reviewing their individual PiR Action Plan. • PiRO is influencing policy and practice with regard to service availability, access and integration. • PiRO prioritises resources for system-level improvements.	• Clear governance and management structures are in place. • PiRO facilitates processes to identify solutions to systematic issues. • The reporting framework is developed and implemented effectively. • Appropriate data systems are implemented to enable accurate and timely reporting, information sharing, and consumer information management. • PiR is operating in a cost effective and value-adding manner.

Table endnote

1 Localised outcome two and localised outcome nine are identical. This outcome has been mapped against national objectives one and three.

6. The sum is greater than the parts



Fundamental to our approach is the belief that the sum is greater than the parts. Engaging partners adds value and helps us to deliver integrated healthcare. The work we have done in conjunction with partners in our three Consortia provides ample illustration of this. In this Section we explore three aspects of this: planning for the future together; working as part of the broader healthcare sector to integrate outcomes; and influencing policy. Together these aspects help us to identify future directions for our collaborative work.

6.1 Planning for the future together

Planning for the future together is critical to ensure that collaborative effort thrives and takes into account environmental changes, including new business opportunities. Examples of planning work our Consortia have undertaken include:

- In December 2014, healthy@home finalised an MOU confirming partnership arrangements and establishing priorities and options for achieving them between then and June 2017. In November 2015, healthy@home established a Strategic Plan that reviewed and updated these priorities and outlined high level strategies and actions for the Consortium between 2015–2018. This Plan is included as a practice example in Section 6.5.1 and has supported healthy@home to identify future directions and steer towards them. In addition, healthy@home has provided advice on broader planning undertaken by the HHS addressing older people's health needs.

- Since 2014, Brisbane North PiR has been working towards broadening its role to one of regional coordination for mental health services. This came to fruition in June 2016 when the PiR Consortium reconfigured as 'Collaboration in MIND,' with the more strategic brief of planning for, and coordinating, mental health services in North Brisbane and Moreton Bay. Collaboration in MIND is chaired by the PHN and will support its role in planning for and commissioning mental health services. In particular, the PHN was funded by the Australian Government in its 2016–17 budget as one of three national sites to trial integrated healthcare packages for people with severe and complex mental illness in its region.
- Members from all three Consortia have also participated in regional health needs assessment undertaken by the PHN, thus making their service delivery knowledge and expertise available to inform broader health needs assessment.

6.2 Working with the broader sector to integrate outcomes

PHNs are tasked with coordinating and integrating healthcare outcomes. Working with the three Consortia has presented ample opportunities for integrating outcomes both in terms of work within the Consortia and work across the broader healthcare sector. Some of the strategies we have used to work towards integrated outcomes both within our Consortia, and with the broader healthcare sector, are outlined below:

HHS's role as a foundation partner in the three Consortia

The HHS's role as a foundation partner in the three Consortia connects healthcare services and programs funded by the Queensland Government directly with the services delivered by the three Consortia using funding provided by the Australian Government. This allows for vertical integration between Australian and Queensland Government funded programs and services in the fields of community aged care and mental health and provides an illustration of how collaborative ventures can provide a vehicle for more integrated outcomes.

Building cohesive service delivery models

These models deliver a consistent service experience for consumers accessing services provided by all partners. For example, Consortia members have greatly improved consumer pathways between Consortia members' services and resources and tools have been developed that underpin consistent consumer experiences. These strategies, along with joint professional development activities by staff in partnering organisations, make for a more connected approach amongst Consortia members. This, in turn, delivers more integrated outcomes for consumers. In interviews Consortium members were asked to identify how their work had added value to consumer services. Responses commonly focused on 'back end' influences such as training, the quality lead role and resources and tools that underpinned consistent and collaborative service delivery as examples, as well as improved referral pathways.

Funding specific projects that achieve integrated consumer outcomes

A number of specific projects illustrate how the Consortia have worked effectively towards integrated outcomes. For example, the PHN has recently funded an innovative new healthy@home project that tasks one Consortium partner with training community care staff from all partners offering in-home services, in an evidence based exercise program that will support older people to improve their health at home while in-home support is occurring. A further example is provided by systems reform projects in PiR, which have worked across many sectors to deliver stronger and more integrated mental health outcomes for people experiencing severe and persistent mental health issues. Systems reform projects have engaged sectors as varied as employment services; peer and volunteer support services; community pharmacies; and affordable housing providers.

PiR forums

Each year, Brisbane North PiR hosts forums across the region to engage consumers, carers and service providers from a range of organisations and sectors to identify and discuss issues for people experiencing mental health issues and to co-create responses to these needs. The forums have also provided an opportunity to discuss the mental health service system during a period of substantial change driven by a national review resulting in many changes, including a move by the Australian Government to task PHNs with responsibility for regional priority setting and decision making about mental health services that the Australian Government provides funding for. Forums have attracted many participants, demonstrating strong engagement across the region. Section 6.5.2 includes a flyer for Brisbane North PiR Forum 2015 as an illustration.

Aged care forums

Consortium partners from healthy@home and the RAS Consortium also participate in Aged Care Sector Development and Support Forums established by the PHN. In November 2013, the inaugural Forum was held and these have continued on a quarterly basis since that time, attracting up to 200 attendees. The Forums provide an important opportunity for the aged care sector to network, share information and undertake professional development together. Similar to the PiR forums outlined above, these Forums have filled the need for a communication mechanism through a period of substantial reform to the sector, with progress towards consumer directed care entailing a range of program and service delivery changes.

6.3 Influencing policy

At a strategic level, working with partnering organisations has presented opportunities to use our collective experience of service delivery and of managing local programs to provide input into, and to influence, broader policy. Partnering organisations and consumer and carer representatives from the three Consortia provide us with much more detailed and sophisticated input on the challenges associated with service delivery and its impacts.

Our work on community aged care through the RAS and healthy@home Consortia provides an illustration of how we have found opportunities to provide input to, and to influence, policy directions. The following table outlines some of the opportunities we have used to do this.

healthy@home		
What we did	When	What it was about
National Aged Care Alliance.	August 2013 – July 2015	Brisbane North PHN was representative of the Australian Healthcare and Hospitals Association (AHHA) on the National Aged Care Alliance (NACA), an advisory committee to the Australian Government.
Gateway Advisory Group.	November 2014	Brisbane North PHN became the representative of the AHHA on the Gateway Advisory Group, a sub-committee of NACA.
Provided input to a range of policy and program positions/ processes/consultation opportunities.	April 2015–March 2016	• National Guide to the CHSP Client Contribution Framework • Aged Care Short-Term Restorative Care Program Policy Consultation Paper • Increasing Choice in Home Care – Stage One Discussion Paper • CHSP Service Gap Analysis Survey.
Presentation at NACA meeting.	May 2016	To promote awareness of healthy@home and the Consortium approach with the national advisory structure for aged care reforms.
International Federation of Ageing Conference – Brisbane.	June 2016	Representatives of healthy@home attended the conference and facilitated the healthy@home workshop and e-poster presentations were made.
Older Persons Health Service Plan Project Steering Committee.	August 2016	Participated in the Steering Committee to develop the HHS's Older Persons Plan 2016–21.
RAS Consortium		
Consortium meeting with Dr. Margo McCarthy, Deputy Secretary of Ageing from Department of Health.	February 2016	Consultation with our Consortia on integration and aged care.
Consortium meeting with the Hon. Ken Wyatt AM MP, Assistant Minister for Health and Aged Care.	March 2016	An opportunity for the Minister to meet and address healthy@ home members and for members to provide an overview of the Consortium's activities and achievements.
National RAS Workshop with Department of Health.	June 2016	13 RAS organisations from across Australia met with the Department to discuss RAS performance, strategic direction and community of practice initiatives.

6.4 Future directions

Between 2012 and August 2016, our work in establishing and sustaining the three Con-

sortia we have used as practice examples in this Toolkit has provided strong foundations for our approach to collaboration as a PHN. Research for this Toolkit tells us that both PHN managers and our partners have found the experience to be enriching, immensely developmental in nature and sometimes exhausting. Feedback provided through research was overwhelmingly positive but showed that Consortia members see substantial changes in their future environment and believe that new and different work will need to be undertaken to face these challenges as well as to continue their collaborative effort. Some Consortium members also identified other settings they felt this collaborative approach could contribute to including service provision as part of the NDIS; delivery of mental health services other than PiR; alcohol and drug treatment programs; service coordination for special needs groups and advocacy for older people. A sample of reflections on future directions from Consortium members is provided below.

What Consortium members said about future directions

> "Now, it's still a lot of work to keep us true to our collective approach. You know, honouring our partners in an environment that is really setting us against each other so I think we will always just have to keep working at it."

> "Personally it's just really fulfilling and reassuring. It's great to think that people embraced an idea and are doing it."

> "I think this is a really positive thing that is happening and I'm really keen to find out how it works. I think it has a lot of applicability in other settings."

> "In more recent times, I've become more of an advocate of this sort of model of operation and am looking at other environments in which this could be replicated."

> "Where I stand now is that, I think, there is great excitement in other opportunities and the learnings that we've all come across in doing this way of things. Perhaps, you know, we will do it differently into the future."

6.5 PRACTICE EXAMPLES AND RESOURCES

6.5.1 healthy@home Strategic Plan

In late 2015, healthy@home undertook a planning exercise resulting in a Strategic Plan outlining future priorities and strategies for the Consortium. The Plan is included below as a practice example.

STRATEGIC PLAN | 2015 – 2018

healthy@home

CONSORTIUM MEMBERS

- Brisbane North PHN
- All About Living
- BallyCara
- Burnie Brae
- Carers Qld
- Centacare
- Co.As.It
- Community
- COTA
- Footprints
- GOC Care
- Institute for Urban Indigenous Health
- Jubilee Community Care
- Leading Age Services Australia Qld
- Metro North Hospital and Health Service
- Nundah Activity Centre
- Queensland Aged and Disability Advocacy
- RSL Care
- Wesley Mission Brisbane

improving older people's well-being

delivering quality service

keeping people healthy and at home

valuing diversity

Our Strategies

Who we are

Our Consortium consists of 19 organisations committed to providing quality services to older people in Brisbane's northern suburbs and the Moreton Bay area:

- Brisbane North PHN leads the Consortium as part of its role in connecting health care to meet local needs.
- Metro North Hospital and Health Service works as part of the Consortium to enhance health outcomes.
- Member organisations provide quality services to older people in their homes and communities.
- Member organisations provide an expert understanding of the needs of older people and of carers as well as of the aged services industry to help us deliver high quality services.

Our services

- Enable people to be healthy and at home
- Focus on the consumer and the outcomes they need
- Connect with primary health care providers
- Are high quality and based on evidence about what works for older people
- Respond to the needs of diverse groups of older people such as Aboriginal and Torres Strait Islander people, people from different cultural backgrounds and homeless people.

Consumers can expect us to

- Work with them to find out what they need
- Design services with them that get the best outcome
- Deliver the right services at the right time in the right place
- Consistently deliver high quality services
- Involve them and their carers in planning and decision making
- Seek feedback from them and use it to improve our services.

We will know we are doing well when

- Consumers using our services improve their well-being and independence and connect more with their communities
- We have integrated care pathways in place
- GPs, hospitals and other health care providers know about our services
- We have a high level of knowledge about the needs of our consumers
- We receive consumer and carer feedback and act on it
- We improve our service delivery through ongoing training and continuous quality improvement
- We represent the Consortium's perspective to policy makers
- We assess how our partnership is going.

1 Develop integrated care pathways that link to primary health care

a. Promote the Consortium's CHSP services to GPs, hospitals and other primary health care providers and networks.
b. Identify key services and programs for older people delivered by Consortium members and establish integrated referral and care pathways for these.
c. Use aged care forums hosted by Brisbane North PHN and other interagency networks to promote our model for integrated referrals and care pathways.

2 Build our knowledge about consumers and what they need

a. Measure changes to well-being, independence and connection to community for older people using our services.
b. Engage consumers and carers in local service evaluation project.
c. Involve consumer and carer representatives in the Consortium's governance structures.

3 Expand and diversify our service delivery

a. Seek funding opportunities for new and different service delivery including for extension of allied health services.
b. Explore options for extending geographic catchment areas for service delivery.
c. Strengthen capacity to respond to diverse consumer groups.
d. Join the fee for service market.
e. Update our Consortium's structure and governance arrangements to support growth and diversification.

4 Influence policy direction

a. Participate in the policy process for integration of CHSP and Home Care packages.
b. Participate in the policy process for consumer directed care.
c. Provide feedback on implementation of My Aged Care.

Brisbane North PHN acknowledges the financial and other support from the Australian Government Department of Health.

6.5.2 Brisbane North PiR Forum 2015

Each year Brisbane North PiR hosts a forum seeking participation and input from people and organisations across North Brisbane and Moreton Bay involved in mental health. The following flyer illustrates the approach and agenda for these forums.

You are invited to....

THE 3RD ANNUAL NORTH BRISBANE PARTNERS IN RECOVERY FORUMS 2015

Working together to support recovery: Shaping the future

TUESDAY 6 OCTOBER 2015 - REDCLIFFE | WEDNESDAY 14 OCTOBER 2015 - NEW FARM

North Brisbane Partners in Recovery will host the third annual PiR forums as part of Mental Health Week.

This year's forums will include discussion on shaping the ongoing and future changes to the mental health system and the issues affecting the sector, people living with a mental illness and helping them on their road to recovery.

250 people from across the region will come together at the two free events, to co-create solutions, showcase innovative practice, network with colleagues and learn more about the work of Partners in Recovery.

By attending you will:

- co-create solutions to systemic issues facing people with a mental illness and the mental health system
- share knowledge, contacts and innovative practice
- hear about the progress made by PiR in the past year
- learn more about PiR and how it supports consumers and providers.

Who should attend?

- consumer and carer representatives, volunteers, peer workers and management committee members;
- frontline mental health workers and other community workers with an interest in mental health;
- health and community service managers, researchers and policy makers.

Registration is available online
www.northbrisbane.pirinitiative.com.au/pir-forum/

For further details, please contact Events and Marketing Officer, Danielle Francisco on 07 3630 7344 or email danielle.francisco@brisbanenorthphn.org.au

BRISBANE NORTH PHN | NORTH BRISBANE PARTNERS IN RECOVERY

This is an initiative of the Australian Government.

Appendix 1: List of interviewees and workshop participants

Consortium members generously contributed their time to development of this Toolkit through interviews and attendance at a workshop. Interviewees and workshop attendees are listed below.

Interviewees	
Name	Role/organisation
Angela Andronis	Director, GOC Care
Jeff Cheverton	Former Deputy CEO, Brisbane North PHN
Pauline Coffey	Executive Manager, Commissioned Services, Brisbane North PHN
Karen Dare	CEO, Communify
Duncan Henderson	HomeCare Manager, RSL Care/RDNS
Paul Johnson	Chief Operating Officer, BallyCara
Jan Kealton	Carer representative, PiR Consortium
Tanya Miller	State Manager, Neami National
Geoff Rowe	CEO, Aged and Disability Advocacy Australia
Michele Smith	Manager, Community Care, Brisbane North PHN
Craig Stanley-Jones	Regional Manager Queensland, Partnerships and Collaboration, Aftercare

Workshop participants	
Name	Role/organisation
Angela Andronis	GOC Care
Donna Bowman	Open Minds
Adam Campbell	Carers Queensland
Jeff Cheverton	Brisbane North PHN
Pauline Coffey	Brisbane North PHN
Karen Dare	Communify
Anthony DeWaard	Metro North Hospital Health Service
Melody Edwards	Queensland Alliance for Mental Health
Duncan Henderson	RSL Care/RDNS
Paul Johnson	BallyCara
Cassandra Loane	Consumer representative, PiR
Paul Martin	Brisbane North PHN
Louise Maudlin	Brisbane North PHN
Kay McManus	LASA Q

Workshop participants	
Name	Role/organisation
Tanya Miller	Neami National
Sarah Mitchell	Centrecare
Matthew Moore	The Institute for Urban Indigenous Health
Julie Morrow	Brisbane North PHN
Jennifer Pouwer	Mental Illness Fellowship of Queensland
Dina Ranieri	Co.As.It
Shaun Riley	Jubilee Community Care
Kevin Rouse	Burnie Brae
Geoff Rowe	Aged and Disability Advocacy Australia
Peggy Skehan	Footprints
Michele Smith	Brisbane North PHN
Tonita Taylor	Brisbane North PHN
Cherylee Treloar	Footprints
Mark Tucker-Evans	COTA
Jo Walters	Metro North Hospital Health Service
David Worsnop	All About Living
Julie Yule	Wesley Mission Queensland

Appendix 2: References

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