

# Guidelines for the **Connecting Healthcare In Communities** Initiative

## Primary Healthcare Partnership Councils

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## 1. Executive Summary

In the primary health care sector, there exists varying levels of collaboration, communication, consultation and information sharing in the pursuit of healthier communities. At times, however, stakeholders have experienced difficulties in these relationships, particularly with regards to expectations of service provision, funding, access to information and participating in strategic development and policy direction for specific issues.

The *Connecting Healthcare in Communities (CHIC) Initiative* represents a proactive approach to establishing partnerships to minimise duplication, improve integration and service coordination and potentially increase the capacity of the health system, to improve the health of Queenslanders.

The Partnership Councils will focus on chronic and complex care, integrated health promotion and illness prevention, early childhood health, community mental health and drug and alcohol services.

Partnership Councils will consist of stakeholders such as general practitioners, community nursing services, community controlled Aboriginal and Torres Strait Islander health services, Divisions of General Practice, relevant community and hospital services, and consumer representatives.

Joint governance arrangements and broad stakeholder consultation has been adopted across the primary health care sector to progress this important initiative. Key partners in providing state-wide governance for the CHIC Initiative include Queensland Health, Commonwealth Department of Health and Ageing, General Practice Queensland (GPQ), the Queensland Aboriginal and Islander Health Council and the Combined Health Agency Group (CHAG) – a multi-agency group representing Blue Care, Spiritus, Queensland Health Community Health, RSL Care and Ozcare.

Each Partnership Council will:

- develop arrangements where all members of a Partnership are equal partners in delivering primary health care services, and improving population health outcomes
- jointly develop and implement local service delivery plans for primary and community health care; and
- foster and reward innovative approaches to primary health care service delivery.

The CHIC Implementation Team, including a statewide manager and coordinators in the Northern, Central and Southern areas, will provide an effective means of leading and supporting the implementation for the first three (3) years.

Queensland Health is investing approximately \$34 million over five (5) years, commencing in 2006/07, to implement the Partnership Councils and promote innovation in primary health care service delivery.

Partnership Councils will be reviewed to ensure they continue to achieve the aims that are outlined in the CHIC Guidelines. Independent evaluation will be undertaken encompassing all aspects of the Initiative.

These Guidelines provide an introduction to the scope of the CHIC Initiative and include clear guiding principles for the establishment and operation of the Partnership Councils.

They also include suggested membership, governance structures, available resources and expected evaluation outcomes.

## **2. Introduction**

### **2.1 The Connecting Healthcare in Communities Initiative**

The *Connecting Healthcare in Communities (CHIC) Initiative* represents a joint approach to establishing partnerships in the primary health care sector to improve the health of Queenslanders and increase the capacity of the health system over the next five (5) years to June 2011.

The CHIC Initiative will establish local collaborations in primary health care aimed at enhancing service coordination and delivery through:

- shared planning and service delivery
- shared assessment tools;
- common management protocols;
- agreed roles in patient support and education; and
- local community health promotion action.

These formal partnerships will be known as *Primary Health Care Partnership Councils* (Partnership Councils) and approximately 16 will be established within the geographical boundaries of the Queensland Health Service Districts. The Partnership Councils, in focussing on enhancing service coordination and sharing service delivery, will target the reduction of risk factors and provide better primary clinical care, in turn leading to reductions in avoidable admissions, inappropriate referrals to outpatient services and improved quality of life.

Each Partnership Council will be required to jointly identify a locally relevant priority from existing data and health plans and deliver shared primary health care services from within the scope of the Government health priorities of chronic and complex care, integrated health promotion and illness prevention, early childhood health (including ante and post natal care), community mental health and drug and alcohol services.

Partnership Councils will be supported and guided under a joint governance structure which includes representation from key primary health care service provision agencies, at both the Area CHIC Partnership and Statewide CHIC Partnership level.

## **3. Characteristics of Primary Health Care Partnership Councils**

### **3.1 Guiding Principles**

Partnerships in primary health care may usefully be seen to range on a continuum from networking through to collaboration. It is envisaged that the Partnership Councils will progress along such a continuum to ultimately become effective service delivery collaborations (Attachment 1).

Each Partnership Council will:

- recognise the diversity of providers funded to deliver primary health care services
- through collaborative action build primary health care service provision capacity across the sector;
- where possible be formed within the Health Service District boundaries and assist in more effectively identifying and prioritising the health needs of the local people, and respond to the pressures on the health system in the catchment area;

- collaboratively develop local, integrated implementation plans for primary health care;
- commit to governance arrangements where all members of a Partnership are equal partners in making decisions on the planning and delivery of primary health care services;
- more effectively engage local service providers as key partners to identify and prioritise health needs and the feasible delivery of health services;
- foster, facilitate and promote innovative approaches to primary health care service planning and delivery; and
- identify opportunities for information sharing and the development and uptake of common tools to ensure efficient collection of information.

### **3.2. Key Partners**

Key partners in providing state-wide governance for the CHIC Initiative include Queensland Health, General Practice Queensland (GPQ), Queensland Aboriginal and Islander Health Council, Commonwealth Department of Health and Ageing and the Combined Health Agency Group (CHAG) – multi-agency group representative of Blue Care, Spiritus, Queensland Health Community Health, RSL Care and Ozcare.

Membership of the local Partnership Councils will vary across the State although will predominantly include primary health care service providers. All opportunities will be taken to ensure the membership is closely representative of all interested primary health care service providers within the catchment area.

Partners will include Queensland Health primary health care and community health staff, Divisions of General Practice, General Practitioners, community controlled Aboriginal and Torres Strait Islander health services and non-government health service providers. Where appropriate, Partnership Councils may also include individual health professionals in private practice, Department of Communities and other relevant government agencies or community/consumer groups. The range and level of involvement of partners will be voluntary and determined by consensus at the local level.

## **4. Implementation**

A CHIC Implementation Team will be established to provide an effective means of leading and supporting the Initiative at the State, Area and District levels for the first three (3) years. The Team includes the Statewide CHIC Coordinator, three Area CHIC Coordinators and Administrative support.

In addition to existing local and Area level planning, Partnership Council implementation plans may benefit from by being informed by the Regional Health Forums, which are progressively being established within Queensland as part of implementing the Framework Agreement for the Queensland Aboriginal and Torres Strait Islander Health Partnership (QATSIHP). The CHIC Initiative and its' Partnership Councils will recognise the work already done by the Regional Health Forums and work with the QATSIHP Partnership to clarify the interface between the two mechanisms.

In June 2006, the Minister provided \$2.5M one-off funding to GPQ for the *Capacity for Local Partnership Initiative* to support each Division of General Practice across Queensland to identify and build partnership structures as a mechanism for joint planning, priority setting and implementation of locally identified strategies under the Qld Strategy for Chronic Disease 2005-2015. The key objectives of this initiative were to support the trialling and refinement of local partnerships and to inform future primary health care partnership

structures (such as Partnership Councils) as a mechanism for planning and implementation of other initiatives at the local level.

Where timely and appropriate, the development of CHIC Partnership Councils may initially progress through the consolidation and expansion of these, or other existing partnership arrangements. All efforts should be made to maintain flexible arrangements and avoid duplication of existing partnerships. Existing partners will jointly identify other partners, through an initial process of open invitation.

#### **4.1 Outcomes**

It is expected that following the development of Partnership Councils there will be improved integration of primary health care service delivery and planning across Queensland, with benefits for consumers and service providers.

By the end of 2009, it is expected that the establishment of Partnership Councils in Queensland will demonstrate significant improvement in the following areas:

##### ***Individual and community levels:***

- better access to primary health care services for Queenslanders
- relevant health and personal information is shared, in accordance with privacy provisions, between health services to reduce duplication and improve continuity of care, especially for people with chronic disease and complex needs;

##### ***Health systems level:***

- improved integration in health service delivery;
- collaborative action in response to emerging issues and priorities for the health system;
- better utilisation of scarce resources, including workforce management and development;
- reduction in the number of avoidable admissions to hospitals;
- reduction in the number of avoidable presentations to emergency departments; and
- reduction in the number of inappropriate referrals to hospital outpatient departments.

#### **4.2 Governance Arrangements (See Attachment 2)**

##### **4.2.1 State Level**

The **Statewide CHIC Partnership** is representative of the key stakeholders in primary health care who have overarching responsibility for the governance and guiding direction in leading and supporting the CHIC Initiative throughout Queensland. This group will receive secretariat support from the Statewide CHIC Coordinator.

The role and responsibilities of the multi-organisational Statewide CHIC Partnership is to provide high level advice, guidance and leadership at a state-wide level, in relation to:

- All policy, organisational, funding and evaluation principles and priorities for the establishment and development of the Primary Health Care Partnership Councils;
- Ensuring engagement and commitment of the key stakeholders and the constituents they represent, at all levels of implementation.
- Identifying and addressing system enablers, barriers and issues in the implementation of effective Primary Health Care Partnerships, which are common across the state. For example, partnership and funding guideline development, capacity building framework, communication strategies, evaluation framework and template and tool development.

- Providing the Partnership Councils with access to, and facilitate the use of, the evidence base on innovative service delivery implementation, partnership support tools and intellectual capacity building opportunities in partnership development and shared service delivery;
- Encouraging and facilitating opportunities for sharing of information and progress, between partnerships, throughout the state.
- A brief review of the Partnership Councils in 2009
- Policy, planning and implementation responses to the Final Evaluation of the Partnership Councils in 2011.

The **CHIC Working Group** is representative of the key stakeholders and includes the CHIC Implementation Team and provides operational advice and support to the **Statewide CHIC Partnership**.

#### 4.2.2 Area Level

**The Area CHIC Partnerships** will have overall responsibility for the implementation and support of the Partnership Councils which fall within the respective boundaries of Queensland Health, Health Services Areas. This group will consist of key stakeholders, representative of the Area's primary health care service providers and will include secretariat and implementation support provided by the Area CHIC Coordinator.

The role and responsibilities of the multi-organisational Area CHIC Partnerships is to provide area level support and drive the implementation of Partnership Councils by:

- Working with District level primary health care service providers in identifying existing local collaborations or multi-stakeholder forums which may prospectively grow to function as Partnership Councils;
- Providing the Partnership Councils with access to relevant data and existing health service planning to assist in their choice of intervention within the government health priority areas.
- Identifying those Partnership Councils eligible for 'service delivery and innovation funding' in Nov 2007, and then again in May 2008 to deliver initiatives.
- Assess Partnership Council Implementation Plans for 'service delivery and innovation funding' utilising mechanisms which ensure a transparent, accountable and equitable process, while avoiding possible conflicts of interest.

#### 4.2.3 Partnership Council Level

The **Partnership Council's** governance arrangements and structures will vary to meet the distinctive needs and capacity of member agencies and local circumstances, including the number and type of participating agencies and the election of an honorary chair person. Partnership Councils will need to demonstrate that all opportunities have been taken to ensure their membership is closely representative of the primary health care service providers, within the catchment area.

These governance arrangements will be formalised by the development and execution of MOUs or similar such mechanism, as developed and agreed upon by the Partnership Council members. These agreements will clearly define the underpinning principles, roles and responsibilities, shared goals, priorities and outcomes, as well as communication and accountability mechanisms for each of the partners.

Partner organisations and/or agencies will be expected to incorporate their Partnership Council's accountabilities, principles and shared priorities for action, into agency specific planning and reporting processes. For example, Queensland Health as a key member on the

Partnership Councils will require District and Area staff to report on the activities and outcomes of the relevant Partnership Councils as part of their Performance Agreements.

## **5. Capacity Building, Evaluation and Review**

### **5.1 Capacity Building**

The majority of evidence for partnerships in health care recognises the importance of building the partnering capacity of the primary health care sector. Capacity building may include developing thought leadership and understanding of partnership models, the development of common assessment tools and pathways to support integration and improved service coordination. Capacity building may also involve adoption of a quality improvement approach to include developing structured approaches to communication, innovative service delivery and opportunities for joint training to build skills at locally facilitated workshops.

The Statewide CHIC Partnership recognises and supports the need for significant capacity building work to be implemented. Greater detail around capacity building for the CHIC Initiative will be outlined in an Options Paper.

### **5.2 Evaluation**

Funding has been committed to engage expertise to develop a detailed set of realistic evaluation parameters for the CHIC Evaluation and commence the evaluation process. The Evaluators will be involved in developing a suite of key performance indicators, identify existing data sources, gathering baseline data and assessing capability of Partnerships Councils. It is envisaged the Evaluators would liaise closely with the Capacity Building expertise to inform the development of approaches which allow for sustainable shared primary health care service delivery.

Where appropriate member organisations will be encouraged to negotiate the inclusion of agreed key performance indicators in service level agreements, or the equivalent.

Though the evaluation of the Partnership Councils will be conducted as a separate process, it is recognised that the outcomes of the evaluation of the *Queensland Chronic Disease Strategy (QSCD) 2005 - 2015*, the three Place-Based Initiatives, the Health Contact Centre (13Health), the Capacity for Local Partnership Development Initiative and the four-year COAG *Australian Better Health Initiative 2006-2010*, will inform this process.

### **5.3 Review**

Partnership Councils will be reviewed to track progress and ensure they continue to achieve the aims as outlined in the Guidelines. There will be a brief review in 2009, two years after the implementation of this Initiative, though it is recognised that many Partnership Councils will be still in the development phase. The CHIC Implementation Team, in collaboration with the Statewide CHIC Partnership and the appointed Evaluator, will develop a review plan that outlines the key questions, performance measures and methodology.

## 6. Resources

Queensland Health is investing approximately \$34 million over five (5) years, commencing 2006/07, to implement the Partnership Councils and promote innovation in primary health care service delivery. \$12.5 million of this funding is part of the State Government's contribution to the Australian Better Health Initiative (ABHI).

Funding will be provided for the first three years to encourage and enable the Partnerships Councils to work collaboratively to achieve specific outcome-related objectives.

Firstly, **'partnering funding'** will be allocated for establishment, coordination and support of each Partnership Council. Decisions around the location of this secretariat funding, the auspicing organisation, the election of an honorary chair person and the extent of support required by the Partnership Council will be made via consensus of those Partnership Council members.

Secondly, **'service delivery and innovation funding'** will be available to Partnership Councils based on the merit of a jointly developed implementation plan submitted to the Area CHIC Partnership. The implementation plans will be assessed for funding by the Area CHIC Partnership against an agreed set of criteria. These criteria are likely to include considerations for innovation, partnership, priority, feasibility and capacity to impact on the chosen health priority area.

Funding guidelines will be developed and endorsed by the Statewide CHIC Partnership and include measures to ensure the integrity and transparency of the funding allocation process.

Funding will initially be held at the Area CHIC Partnerships for distribution to the Partnership Councils.

Allocation of **'partnering funding'** will be based on the number of Partnership Councils within the geographical area. E.g. Northern (6), Central (5) and Southern (5).

The allocation of **'service delivery and innovation funding'** to be held by the Area CHIC Partnerships to award to the Partnership Councils (on the merit of their joint submission) will be based on the Queensland Health Resource Allocation Model (2007/08).

- Northern CHIC Partnership – 18.8 %
- Central CHIC Partnership – 36.5 %
- Southern CHIC Partnership – 44.8%

**Non-recurrent funding**, resources and services have also been earmarked for one off innovation and capacity building activities. The preferred approach for use of these funds is to build the capacity of the primary health care sector in thought leadership and understanding of partnership models and the development of common tools and pathways to support integration and improved service coordination.

## **7. Relationship to the COAG Australian Better Health Initiative (ABHI)**

One of the five priority areas for action identified under ABHI is *Improving integration and coordination of care* for better delivery of care and services between primary health care providers. ABHI has provided an incentive fund to contribute to system-wide improvements in service delivery in the primary health care sector. The CHIC Initiative is Queensland Health's operational response to this integration strategy. It is envisaged that as a result of the CHIC Initiative, the improved integration of primary health care and community health services will support the successful implementation of other measures under ABHI.

### **7.1 Announcement protocols**

As Queensland Health has provided sole funding for the establishment of Partnership Councils, the Minister for Health will make all announcements in relation to that activity, noting that the ABHI is a joint Australian, state and territory government initiative. Where multiple funding sources emerge, communication protocols will be reviewed accordingly.

## Attachment 1: Excerpt from Vic Health: Primary Care Partnerships Analysis Tool

### What is a partnership?

The concept of partnerships used in this document implies a level of mutuality and equality between agencies. There are different types of partnerships in primary health care, ranging on a continuum from networking through to collaboration.

**A distinction can also be made between the purposes and nature of partnerships.**

**Partnerships in primary health care may usefully be seen to range on a continuum from networking through to collaboration. It is envisaged that the Partnership Councils will progress along such a continuum to ultimately become effective service delivery collaborations.**

### A continuum of partnerships in primary health care

- **Networking** involves the exchange of information for mutual benefit. This requires little time and trust between partners. For example, youth services within a local government area may meet monthly to provide an update on their work and discuss issues that affect young people.
- **Coordinating** involves exchanging information and altering activities for a common purpose. For example, the youth services may meet and plan a coordinated campaign to lobby the council for more youth-specific services.
- **Cooperating** involves exchanging information, altering activities and sharing resources. It requires a significant amount of time, high level of trust between partners and sharing the turf between agencies. For example, a group of secondary schools may pool some resources with a youth welfare agency to run a 'Diversity Week' as a way of combating violence and discrimination.
- **Collaborating.** In addition to the other activities described, collaboration includes enhancing the capacity of the other partner for mutual benefit and a common purpose. Collaborating requires the partner to give up a part of their turf to another agency to create a better or more seamless service system. For example, a group of schools may fund a youth agency to establish a full-time position to coordinate a Diversity Week, provide professional development for teachers and train student peer mediators in conflict resolution.

*Adapted from: Himmelman A 2001, 'on coalitions and the transformation of power relations: Collaborative betterment and collaborative empowerment', American Journal of Community Psychology, vol. 29, no. 2.*

Not all partnerships will immediately move to collaboration. In some cases, networking is the most appropriate initial response. The nature of the partnership will depend on the need, purpose and willingness of participating agencies to engage in the partnership.

As a partnership moves towards collaboration, the more embedded it will need to become in the core work of the agencies involved. This has resource and structural implications. In particular, collaborative partnerships require the support and involvement of senior agency personnel, since project workers may be relatively junior or on short-term contracts. This can affect their capacity to mobilise the agency resources required for collaboration.

### Working at partnerships

Working collaboratively is not always easy. Rae Walker, in her review on collaboration and alliances<sup>1</sup>, acknowledges the challenges and tensions created by working collaboratively as well as the importance of deciding when partnership is not an appropriate or effective strategy. Walker also describes the critical factors for successful collaboration including the need for partners to establish a process ensuring that organisations develop a shared vision and objectives. Ongoing monitoring and shared reflection of how the partnership is working is critical to strengthening and sustaining relationships between organisations and achieving effective outcomes.

<sup>1</sup> Walker R Sep 2000 Collaboration & Alliances: A Review for VicHealth.

