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INNER NORTH WEST MELBOURNE HEALTH COLLABORATIVE: Early Implementation Evaluation

Final Report August 2015

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This Final Report is provided to the partners of the Inner North West Melbourne Health Collaborative.

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Table of contents

List of Tables

List of Figures

Key Findings

INWMHC AS A FRAMEWORK FOR WORKING TOGETHER

- The Program Logic of the Inner North Inner North West Melbourne Health Collaborative (INWMHC) represents the multi-layered nature of working in partnership.
    - At the strategic level, the mechanism and processes for working together are described as the "Collaborative Framework". This includes the governance arrangements of the Collaborative, and processes to encourage a shared understanding of population needs in the catchment and to undertake joint strategic planning. At the level of the Collaborative Framework, specific tasks and activities are developed, resourced and overseen. It is at this level also that the work done at other levels is considered for its potential to lead to joint planning and redesign at a system level.
    - At the level of "Collaborative Action", the program logic describes how the partners will work together on tasks and activities, with standard ways of working, including project planning, stakeholder engagement, implementation and evaluation against agreed impacts for consumers.
- The INWMHC has established strong governance arrangements as the foundation for the Collaborative Framework.
    - A formal Memorandum of Understanding commits partners to working together. An agreed Strategic Plan developed through a consultative process outlines the shared vision and goals of the four partner organisations for the health system in the region.
    - Chief Executives retain and demonstrate leadership of the Collaborative through regular quarterly meetings. They are provided with the information necessary to support the momentum of the work and to help overcome barriers that may arise.
    - The Senior Managers' Steering Group meets on a monthly basis to operationalise the Collaborative Framework. Their role is pivotal in the ongoing success of the Collaborative and they have been a strong group with consistent membership over the first three years of implementation.
- The Collaborative has put effort into strategic planning and has consulted with stakeholders across the region, particularly through the Annual Collaborative Forum. This has led to agreed priority issues and a Strategic Plan to address them.
- The projects developed, resourced and overseen through the Collaborative during the early implementation phase have been opportunities for joint action around agreed priority areas. They are widely perceived as examples of successful outcomes of collaboration for partner organisations and consumers.
- There is evidence that relationships between staff from partner organisations have benefited from direct contact with each other through activities of the Collaborative. There is better understanding of the roles and capacity of different sectors in the health system, and a stronger sense of shared responsibility for the outcomes of consumers.
- Opportunities to demonstrate the activities and achievements of the Collaborative have been taken up, particularly since 2014, and there is effort to build a shared narrative about the benefits of collaboration that can be communicated broadly across organisations and externally.

NEXT STEPS

- The "story" of the Collaborative needs to continue to be develop and shared. The consequences of partnership need to be captured and reported back to participating organisations at all levels, and to external organisations including health service providers, funders and policy advisors. It is difficult to demonstrate a direct financial cost/benefit case because of the complexities in assumptions required to model the inputs and impacts of collaboration; however, this should not undermine commitment in the face of other evidence of value.
- While the projects have been an opportunity to demonstrate what can be achieved for staff and consumers through working together, extending the collaborative culture in the workforce of all partner organisations requires additional strategies. This could include creating opportunities for those staff who have positive experiences of inter-sectoral cooperation to share their perspectives with colleagues.
- One of the processes that has yet to be determined within the Collaborative Framework is a transparent and systematic approach to considering the implications of the results of focussed activities such as projects on routine practice of all partner organisations.
    - The Collaborative demonstrates all of the characteristics described in the literature for effective collaboration to enable joint action. The exact steps required for the translation of successful projects into system-wide change are not prescribed in any existing models or literature. The INWMHC needs to use the strong collaborative mechanisms and processes it has in place, and the environment of trust and respect that has been built over the past few years, to have robust conversations that challenge each partner to consider what they can do—and can not do—in order to progress system change based on what has been learnt. Investing in an executive/project officer could be an integral part of this.
- As the Collaborative enters the next phase of implementation it will need to actively manage potential risks including:
    - Loss of momentum.
        - It is important that the CEs and SMSG continue to meet regularly to focus on moving the Collaborative forward including considering the outcomes of this evaluation. Ongoing communication of the value of the Collaborative both internally and externally is also important for maintaining momentum.
    - Changes in personnel at the CE and SMSG levels which may undermine the high levels of trust that have been established over the past two years.
        - A systematic approach to inducting individuals taking on these key leadership roles will be essential.
    - Attrition of leading clinicians and health professionals who have developed a more collaborative culture through direct participation in INWMHC activities.
        - Strategies need to be developed to extend the collaborative culture across partner organisations that has been demonstrated to be encouraged by working together on projects.
        - A Communication Strategy that identifies the key messages for different target audiences should be implemented and include ways to extend knowledge of the benefits of working collaborative across organisations.
    - Over-extension of the platform through supporting too many individual projects without demonstrating how the findings of such activities are used to develop the health system more generally through joint planning, redesign and mainstreaming.

- Changes in policy that can put pressure on one or more partner organisations to reduce their overt commitment to the Collaborative. This includes recent changes at the Commonwealth level to primary care policy (Primary Health Care Networks, PHNs) and state-level changes to funding in the acute sector.
    - Any changes in the funding or policy environment should be discussed at the CE and SMSG levels to consider their potential impact on the Collaborative and develop a response.
    - The transition of the INWM Medicare Local to the new Melbourne PHN represents a risk and an opportunity. It is to be hoped that the INWM Health Collaborative remains a priority for the MPHN, and potentially an exemplar of how to develop an effective Framework for collaboration at a local network level.

CONCLUSION

The Inner North West Melbourne Health Collaborative has built a strong platform for ongoing collaboration. The evaluation has demonstrated high levels of trust among partner organisations at a governance level, and a stronger culture of collaboration among health professionals involved in projects auspiced by the Collaborative. The early implementation phase of the INWMHC has been extremely successful, and the Collaborative is in a strong position to extend its reach and influence to achieve impacts for consumers and the community.

Executive Summary

The Inner North West Melbourne Medicare Local (INWMML – now Melbourne Primary Care Network), cohealth (through the former Doutta Galla Community Health), Merri Community Health Services and Melbourne Health are committed to working together to improve patient care, outcomes and pathways for their shared community. The organisations formed a formal partnership in 2012 to pursue shared goals under the title the Inner North West Melbourne Health Collaborative (INWMHC).

An evaluation of the INWMHC partnership was commissioned from the Australian Institute for Primary Care & Ageing, La Trobe University. The evaluation focused on exploring the experience and impact of collaboration from the points of view of multiple stakeholders within the partner organisations. The evaluation involved data collection using a variety of methods and over multiple time points from mid-2013 to mid-2015. Collecting data over time and from multiple sources enables the evaluation to triangulate information in order to provide more robust findings.

Data were collected through:

- Key stakeholder interviews, including interviews with project governance groups (broad group 2014 and 2015; select group late 2014)
- Surveys about the characteristics of collaboration within different governance groups (as part of key stakeholder interviews in 2014 and 2015)
- An online survey of staff from relevant work areas within partner organisations (2014 and 2015)
- Survey of participants at the Annual Collaborative Forum in 2013 and 2014. There were 40 in 2013 and 49 respondents in 2014.

Support for the Collaborative

- Results from all sources indicated strong support for the INWMHC at each time-point and across multiple stakeholders.
    - Results from the online survey of staff in partner organisations provided strong evidence of support, with all respondents, including those who reported knowing little or nothing about the Collaborative (about 55% in 2014 and 35% in 2015), strongly endorsing the statement “I believe there is a need for the Collaborative as a means of improving healthcare in our region”.
    - In 2014 and 2015, more than 95% of respondents to the online survey indicated they believed “the work of the Collaborative will contribute to better health outcomes for consumers in our region”.
    - Results from the survey of Annual Collaborative Forum participants and the online survey of staff in partner organisations suggested that ongoing promotion of a shared understanding of the goals of the Collaborative to all staff in partner organisations was an area to focus on.
- The importance of the Collaborative being clearly endorsed and supported by the partner Chief Executives (CEs) was raised in all rounds of key stakeholder interviews.
    - Many stakeholders stressed the role the CEs play as a link between the achievements and learnings of projects and potential mainstreaming or normalising elements of innovative service redesign at a system level.

Characteristics of the Collaborative

- The evaluation explored the characteristics of the INWMHC from the theoretical perspective of Thomson, Perry & Miller (2007). The results of the online survey and the key stakeholder interviews in 2014 and 2015 indicated that the Collaborative established effective governance and administration functions from the start. This was reflected in clear decision-making processes and a good understanding of roles and responsibilities of members of governance groups. The concepts of autonomy and mutuality refer to the idea that partners have distinct identities and authority that are separate from the partnership (autonomy), but that they are interdependent because of their shared goals and an expectation of mutual benefit (mutuality). This is a challenging aspect of collaborating, and concerns about differences in costs relative to capacity were raised by stakeholders in 2014, and reflected in the online survey. While these aspects of collaborating can be a challenge, the extent to which norms of reciprocity and trust were present in the INWMHC from the start reflects a major strength, and one which is critical to current and future achievements.

Achievements of the Collaborative

- There were clear themes in interviews and surveys in response to questions about the key achievements of the Collaborative.
    - **Joint Projects**: the projects were seen as important opportunities for partners to work together "on the ground" to solve system issues for consumers. They provided a concrete experience of co-operation, particularly as all were required to have a project governance group that involved all partners. In 2015, some projects were drawing to an end and were considering the options for sustaining some or all of the successful elements of their work. The opportunity to discuss and implement mainstreaming and general uptake of project achievements through the Senior Managers' Steering Group and the CE's group is one of the key intended consequences of the INWMHC.
    - **Increased communication and collaboration:** Through the projects and other activities (e.g., Forums, participation in shared activities, governance groups), many stakeholders commented that there was improved communication and understanding of each partner organisation and increased collaboration within and between organisations. This included joint planning and resource sharing, and concrete examples of the contribution of the Collaborative to success in applying for funds to trial new programs or system interventions were noted.
    - **The Collaborative as a platform**: The INWMHC was widely and commonly recognised as a new and effective platform or mechanism to support ongoing catchment-level system redesign efforts.

Implications

The evaluation provides evidence of ongoing support for the stated goals and strategic direction of the INWHMHC.

- There was strong consensus that the Collaborative has been **responding to the highest healthcare needs in the catchment**.
- The joint projects all included aspects of **service redesign to improve coordination, interface and client experiences;** the challenge with any individual project is to consider how to use the findings to influence broader system change, particularly in a way that is efficient and largely delivered with available resources. Part of the ongoing evaluation of the work of the Collaborative (perhaps through

the proposed new Collaborative project officer position) should be to document the way in which the projects have contributed to change across the catchment and beyond. The plan to employ a dedicated worker to support the Collaborative may support and strengthen this function, and contribute to effective processes for translating project-level achievements into more wide-spread system reform.

- The priority of **embracing e-health to improve systems connections** was recognised consistently as a challenge, with many external factors and forces affecting what the Collaborative could do.
- The impact of the INWMHC on **developing a collaborative culture across the workforce** was seen as positive where staff had direct contact with projects or Collaborative activities. The challenge is to encourage culture change within and between organisations, particularly in large health services and particularly those staff who may not have direct contact with partner organisations.
- During 2015, the Collaborative has been taking opportunities to **demonstrate the positive results of collaboration**, including presenting at conferences and including references to the INWMHC when describing the context in which projects are being developed and implemented. The need to continue to focus on measuring and reporting meaningful outcomes was raised through several sources, including as a way to encourage further funding for innovative projects.

Conclusions

There continues to be a strong sense of commitment and enthusiasm about the INWMHC, particularly from those who are more closely involved. Some of the early joint projects endorsed by the Collaborative have recently finished their initial implementation. The next six months represent an important point in the Collaborative's evolution to develop and refine an approach to ensure the effective elements or components of the projects are generalised and inform system redesign across the catchment.

Background

The Inner North West Melbourne Medicare Local (INWMML), cohealth through the Doutta Galla Community Health, Merri Community Health Services and Melbourne Health are committed to working together to improve patient care, outcomes and pathways for their shared community.

The partnership commenced in April 2012, when the Chief Executives of the four organisations started meeting regularly to discuss new opportunities to enhance strategic collaboration. A first joint Collaborative Forum was held in October 2012. The development of a Collaborative Framework in 2013 outlined many of the goals shared by the partners and described measures of success to jointly work towards achieving over the next two to five years:

2 years

- *Two collaborative projects/programs implemented to address priority areas*
- *Annual collaborative forums established*
- *Shared understanding of the population and health needs documented*
- *Strategic Plan for the region developed*
- *Shared Evaluation Framework developed to measure the effectiveness of collaboration*
- *Scope and develop an agreed position on a region based Electronic Medical Record*

5 years

- *New to follow up outpatient ratio at Royal Melbourne Hospital reduced*
- *Collaborative presentations on integrated service models delivered*
- *Collaborative research projects established to provide academic focus to priority area projects/programs*
- *Two collaborative projects are mainstreamed in priority areas*
- *Joint research grants awarded*
- *Mechanism for collecting and analysing client feedback on their journey through the system established*
- *Initial Evaluation of collaboration undertaken*

The *Inner North and West Melbourne Health (INWH) Collaborative Strategic Priorities 2014-17* was developed to articulate the areas upon which the Collaborative should focus to improve the health of the shared community and enhance consumers' experience of an integrated and responsive health care system. The Collaborative seeks to focus in particular on the interface between primary and acute care, recognising that this is the focus with potential to have the most impact for the community.

The five strategic priorities of the Collaborative are:

a. Redesign services to improve coordination, interface and client experiences
b. Respond to the highest healthcare needs in our catchment
c. Drive a collaborative culture across our workforce
d. Embrace ehealth to improve systems connections
e. Demonstrate collaborative results

These priorities are pursued through a number of strategic projects, each one led by a partner organisation.

EVALUATION METHODOLOGY

The Australian Institute for Primary Care and Ageing (AIPCA) at La Trobe University was engaged by the INWMHC to undertake an evaluation of the early implementation of the Collaborative. In particular, the evaluation was designed to explore the way the partnership between Collaborative members functioned in its initial implementation phase, and how the relationships between Collaborative partners and the implementation of projects would contribute to the achievement of the strategic goals of the Collaborative. The focus of the evaluation undertaken by AIPCA was on the way the partnerships between the Collaborative organisations functioned at different levels, and the extent to which the Collaborative worked through individual projects to contribute to short-term impacts.

An evaluation framework was developed by AIPCA in consultation with the Collaborative partners. The framework represents the activities of the strategic plan of the Collaborative and their intended consequences. The evaluation was "formative" or "developmental" in nature, in that the findings of the evaluation were fed back to the INWMHC regularly to inform their ongoing decision-making and planning.

- The program logic describes the "Collaborative Framework" as the mechanism and processes for working together and includes the governance arrangements of the Collaborative, and processes to encourage a shared understanding of population needs in the catchment and to develop shared plans and approaches. At the level of the Collaborative Framework, specific tasks and activities are developed, resourced and overseen.
- At the level of "Collaborative Action", the program logic describes how the partners will work together on tasks and activities, with standard ways of working, including project planning, stakeholder engagement, implementation and evaluation against agreed impacts for consumers.

The Framework articulates the intended consequences of the work of the Collaborative, including the 2-5-year goals described above.

Evaluation Indicators

The program-logic based framework guided identification of the most appropriate methods and indicators to be gathered between June 2013 and June 2015.

Impacts of individual projects developed and implemented with the support of the Collaborative are evaluated at the level of the projects themselves by different means (funded external evaluators, academic partners or in-house). This information is incorporated into the Report where relevant.

Longer term (5-year) outcomes will be explored by the Collaborative in coming years through analysis of routine administrative data collected by partner organisations. This will include reanalysing data that was used to highlight issues to be addressed through the work of the INWMHC that are included as intended indicators of success in five years, including:

- New to follow-up outpatient ratio at MH reduced (care in right place)
- Lower avoidable hospital presentations/ admissions
- Evidence that project-related impacts have spread across partner organisations (and the system over the long term) in order to lead to:
    - efficient delivery of right care in the right place at right time to consumers
    - improved access to coordinated appropriate care (established clinical pathways)

Evaluation Data Collection Methods

The evaluation adopted a mixed methods approach, collecting qualitative and quantitative data at multiple time points between June 2013 and July 2015.

Key Stakeholder Interviews

- Interviews with Chief Executives (CEs), senior managers, project management groups and a number of external stakeholders were conducted in April-June 2014 and June 2015
- Interviews with members of the Senior Managers' Steering Committee were held in November 2014

Survey of governance groups

- A paper-based survey to analyse the strength of partnership and characteristics of collaboration in the key governance groups involved in the Collaborative.
- Completed at the same time as interviews: April-June 2014 and May-June 2015

Online Survey of staff in partner organisations

- An online survey of staff in relevant working areas of partner organisations. Questions explored awareness of the work of the Collaborative, perceived need for the Collaborative, awareness and support for clinical pathways relevant to projects.
- Completed May-June 2014 and May-June 2015

Survey of Annual Forum participants

- A paper-based survey about the Collaborative Framework and perceived impacts of work of the Collaborative. This annual data collection provided an opportunity to monitor the attitudes and commitment of those people who were engaged with or had an interest in the Collaborative.
- Completed October 2013 and October 2014

Other Data Sources

Individual projects were evaluated independently. Relevant information about the projects is incorporated into this Report where available.

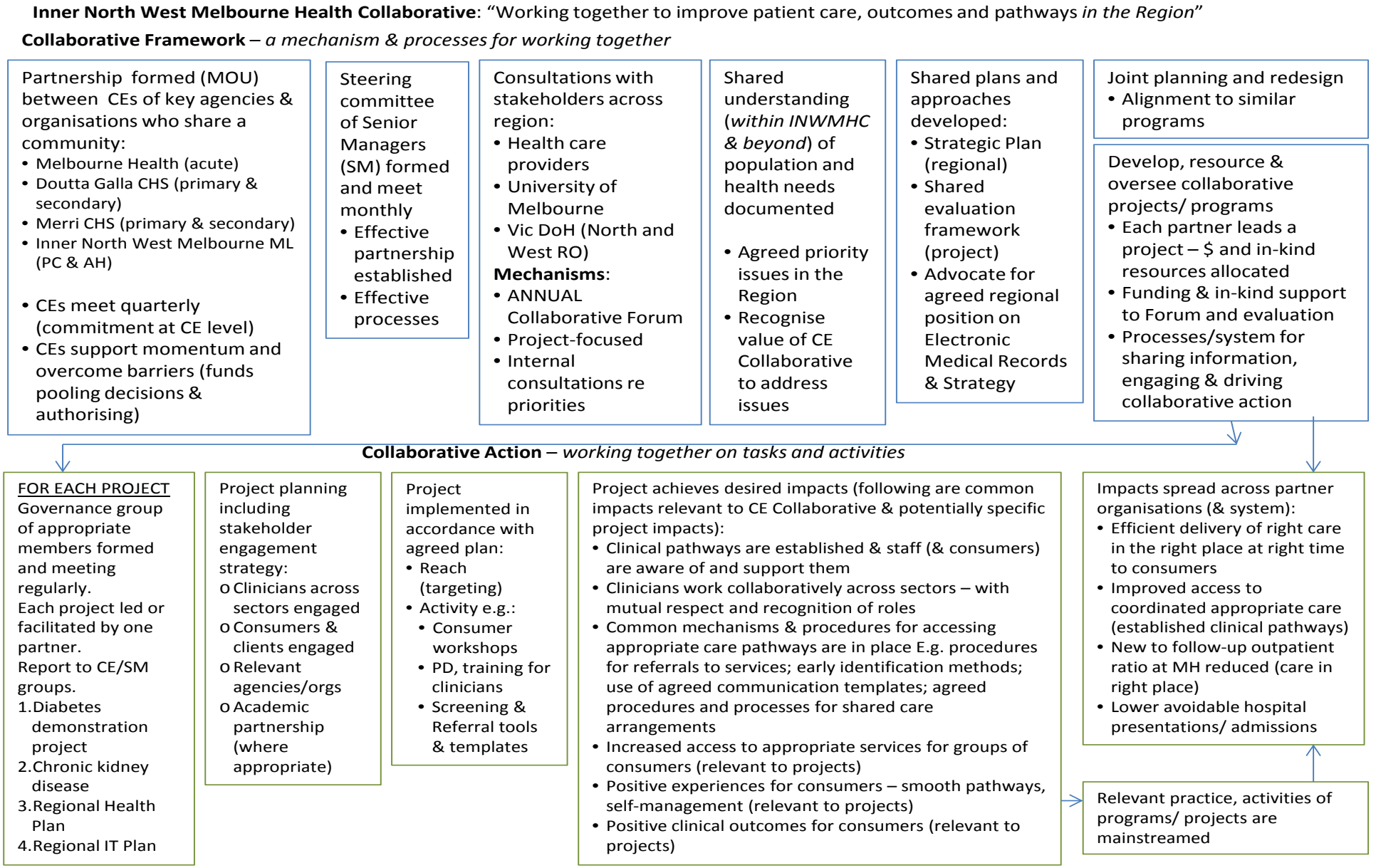

Figure 1: Program Logic representation of the Collaborative Framework and Collaborative Action (developed in consultation with Senior Managers Group)

Overview of INWMHC 2013-2015

The program logic for the INMWHC articulates the vision for how the members of the Collaborative will work together to improve patient care, outcomes and pathways in their shared community. Implementation from 2013-2015 has been consistent with the program logic.

COLLABORATIVE FRAMEWORK: A MECHANISM AND PROCESSES FOR WORKING TOGETHER

The INWMHC established a formal partnership based on an MOU between four key agencies and organisations working in the inner North West of Melbourne.

The CEs met quarterly throughout the period of the evaluation to provide leadership and an overt demonstration of the commitment of each organisation to the Collaborative. Regular meetings of the CE were also intended to overcome barriers as they arose, including approving the allocation of resources to Collaborative activities. The CEs were kept informed about the progress of the Collaborative at all levels through these regular meetings and ensured the strategic direction remained relevant to each organisation. Each CE took opportunities to represent the work of the Collaborative in public, linking the achievements of projects to the Collaborative Framework, particularly during 2015.

The Senior Managers Steering Group (SMSG) met monthly, providing leadership and operational support. It has been a responsive decision-making body to support the activities of the Collaborative. Briefed proxies attended meetings when a SM was unable to attend.

Consultations with stakeholders took place through several mechanisms, key of which was the Annual Collaborative Forum. This Forum commenced in 2012 and the evaluation captured feedback from 2013 and 2014. Further opportunities for engagement and consultation were available through the projects (across partner organisations) and through regular management lines (within each organisation).

The Collaborative developed a Strategic Plan that outlined its shared vision for a better coordinated health care system

COLLABORATIVE ACTION – WORKING TOGETHER ON TASKS AND ACTIVITIES

There were four “flagship” projects identified initially to be led or facilitated by one partner and involving all partners. Partner organisations contributed funding and in-kind support to each of the first four projects. Subsequent projects (lower back pain and advance care planning) are examples of projects for which the Collaborative successfully applied for external funding. As such, they represent achievement of one of the goals of the Collaborative.

1. Regional Health Plan – involving all partners and stakeholder consultation.
2. Improving the ICT interface and e-Health
3. Diabetes Demonstration Project
4. Chronic Kidney Disease Project

5. Lower Back Pain Project (primarily involving MH and MCHS)

A project considering a system-wide approach to Advance Care Planning was developed and successfully applied for external funding in 2015.

Each of the projects formed a project management group and followed routine practice in terms of developing implementation plans and reporting back about project progress.

Evaluation of individual projects was undertaken by external experts and/or academic partners. Reports, including recommendations for sustainability following project completion, were provided to the SMSG and CEs Group. At the time of reporting here, the processes for mainstreaming relevant practice or activities of projects as described in the program logic representation have not been clearly articulated.

Coordinating Community Care for Diabetes (CCC4D)

The Coordinated Care for Diabetes (CCC4D) project had two distinct elements. The first was a trial of insulin initiation among a select group of general practices. The second element was investigating improved models of community-based diabetes care with a focus in 2014 on a comprehensive needs analysis and the development of clinician-led patient pathways. Key outputs included:

- CCC4D diabetes needs assessment
- Healthpathways-Diabetes 21 pages, including:
    - 14 clinical pages
    - 5 referral pages
    - 2 resource pages
- Health professional training and education events
- Diabetes symposium (73 attendees, 29 GPs)
- Insulin initiation masterclass - 38 Attendees: 19 GPs, 17 practice nurses, 2 DNEs
- Quality improvement project workshop
- Consumer focus groups
- Journal of Clinical Nursing article – "Experiences of diabetes self-management: a focus group study among Australians with type 2 diabetes"
- Consumer services guide - **http://www.inwmml.org.au/_uploads/_ckpg/files/Services/Diabetes/DiabetesYourHealthJulyFINAL.pdf**
- Consumer forum - 71 attendees
- General Practice Quality Improvement Program: 8 practices signed to take on a range of practice improvement activities include data cleansing, refresh 'recall& reminder' and multi-disciplinary case conferencing.

Chronic Kidney Disease

The CKD Awareness in Community Health Pilot Program, commenced at MCHS on the 28th July 2014 and at cohealth Niddrie site on the 23rd September 2014.

This project included three key aspects:

- Strengthening the interface between the RMH Renal Service and the Partnerships in Health – CDM Services;
- Strengthening the role of community health services in screening and self-management for people at risk of chronic kidney disease; and

- Improved pathways and engagement of GPs.

Initially, Care Coordinators at MCHS and the Allied Health staff and Community Nurses at cohealth Niddrie and Kensington site administered the program. Education sessions were conducted by a Nurse Practitioner to the Allied Health staff at cohealth who felt they had limited knowledge of CKD and needed further information before they could start to implement the pilot program. A simple online tool was used (the QKidney® risk calculator http://www.qkidney.org) as recommended by Kidney Health Australia to assess the risk of developing moderate to severe kidney disease over the next five years.

The screening/awareness process included:

- Participants must be between 35-74 years of age and not diagnosed with CKD
- Participants complete the online QKidney Risk Calculator
- Client is provided with a copy of QKidney risk calculator results and 'QKidney understanding your results' and given any further information individualised to their needs
- A feedback letter to GP is completed with results, summary of self management plan, proposed referrals and suggested next visit
- The Kidney Health Australia (KHA) 'GP Referral Recommendations' is used to indicate next GP visit

GP engagement was achieved through;

- Development of a CKD Health Pathway
- Monitoring of progress of the E-Map Trial (Western region)
- Participation of GPs in the Australian Primary Care Collaborative Program on CVD and CKD

Back Pain

The aim of the Back Pain project was to reduce the long waitlists for specialist surgical appointments at Royal Melbourne Hospital. Key elements included:

- Establishment of a new approach to MH Triage
    - Triage involves three specialty areas (Rheumatology, Orthopaedics, Neurosurgery) and physiotherapy.
    - Inclusion and exclusion criteria were developed
    - Catchment based criteria were developed
- BAC – Back Assessment Clinic
    - Back pain Assessment Clinic (BAC) at Royal Park Campus and Bell St (MCHS)
    - Rheumatologist and 2 x Grade 4 Physiotherapists
- Management at MCHS and cohealth:
    - MCHS
        - Grade 3 Physio
        - 1:1 initially – functional rehab, manual therapy, dry needling and other therapies
        - Transitioning to generic existing MCHS groups
        - View to developing a back pain specific treatment group in conjunction with Grade 3 Exercise Physiologist and OT
    - cohealth
        - 2 x Grade 2 Physios
        - AHA with Pilates and Yoga backgrounds
        - Some 1:1

- A range of existing groups
- Aiming to develop a back pain specific group run by physio and AHA and a single pain management education session

Key patient outcome measures were used to evaluate the effectiveness of the interventions. An external evaluation was commissioned to undertake data collection including:

- Patient, referrer and staff satisfaction surveys
- Focus group interviews for patient and staff
- Workforce efficiency and effectiveness data including access time, waitlist, resource utilisation
- Measures of cost effectiveness.

All partners were able to align existing related work to the project (service model development in community health and a new position in rheumatology at MH).

CONCLUSION

The work of the Collaborative is not a separately funded "project" being undertaken as a one-off activity by the partner organisations: rather, it represents an ongoing commitment by four significant health organisations in one geographic catchment to improve the design and delivery of healthcare across the care continuum. The Program Logic remains an accurate representation of the work of the Collaborative, and can support future implementation as well as the evaluation.

Findings from Key Stakeholder Interviews

METHOD

Final interviews were undertaken with the chief executives (CEs), senior managers (SMs), project steering group members (as groups for the back pain, chronic kidney disease, diabetes and e-health projects) and selected other key stakeholders. The findings are organised around the questions that were asked. Responses were considered against the themes from the interviews held earlier in 2014 with the intention of considering whether there had been any changes in the views or recent experiences of those interviewed or their organisations.

ACHIEVEMENTS OF THE COLLABORATIVE

Main achievements overall

SMs, CEs and other key stakeholders were asked what they thought were the main achievements of the Collaborative.

Consistent with previous interviews, the main achievements were reported to be improving the interface, perceptions and understanding between the primary and acute sectors, including the development of trust and good will, improving client pathways, and acting as a platform to demonstrate what can be achieved through collaboration, even in a context of significant change. Also mentioned were: the direct achievements of projects; opportunities for innovation; more focus on the most appropriate health care for the community and successes in achieving funding and in winning tenders.

Comments included:

> *"Building a culture of trust and collaboration is something that is difficult – and we've done quite well on that."*
>
> *"Relationship development. The capacity to try some things together that are a bit different to what we have done in the past. .... Demonstration of how we can work together. … in the context of everything changing around us."*
>
> *"Not withstanding how many other things we are involved with and how much other activity has been occurring in our organisations and around them. Still a high degree of purpose for why we should be working together."*
>
> *"Demonstration of the ability to work collaboratively across the continuum – between primary and acute sectors and see the opportunities that are evident there has been very positive."*
>
> *"Bringing together quite diverse partners to focus on shared areas of work. The partnership itself is an achievement and the pieces of work that have fallen out of that."*
>
> *"Collaborative is a platform to experiment with innovative approaches."*

Shifting provision of care

Other stakeholders were asked how the collaborative arrangements were helpful in shifting the provision of care and whether it is being shifted to the right place.

In response to the question, stakeholders gave the development of health pathways and locating clinicians in the community sector as examples of effective mechanisms in shifting the provision of care. It was however also commented that it was early days and that there was still resistance from some in the acute sector. One stakeholder commented that the collaboration provided, "stepping stones to systems change." Another stakeholder commented that, "trust is really important in reorientating care" both for those providing services – acute and primary, and for patients used to being treated in hospitals - that the primary sector will still provide high quality care.

Overwhelmingly, stakeholders supported the move to community based service delivery with the back pain clinic most often cited as a successful example of what can be achieved.

Assistance with own organisation's goals

CE and SMs were asked if being part of the Collaborative, "helped your organisation to achieve your own goals better than you could without it?"

CEs and SMs commented positively on the benefits of being a member of the Collaborative and the importance of getting the partner organisations around the table - "brings us together in a formal way that is incredibly useful to have the conversations we need to be having." One CE commented that it needed to "go up a notch," but that it was early days and the first steps were the hardest.

SM interviewee's responses as to whether assistance provided by the Collaborative supported organisational goals varied from "think so" to "very much so." One SM stressed the opportunities that the Collaborative provided for their organisation to work in areas they would not have otherwise, while another commented that although there was still more work to be done, the Collaborative assisted with improving service delivery to consumers. One stakeholder commented that:

> *"Being part of the Collaborative makes you think about the systems issues and what is best for consumers or clients at a particular point in time. What parts of the system should be doing what. Makes you reflect on what you may or may not be doing so well. Doesn't help overcome frustrations of lack of funding but certainly highlights those things."*

SMs also reported that the Collaborative assisted with accessing new resources citing workforce innovation, funding for the back pain clinic and advanced care planning projects, and co-contribution of the Collaborative evaluation.

Cost/ benefit of collaborating

CEs and SMs were also asked if participation in the Collaborative had been worth the cost of participation and whether the benefits of membership are equitably distributed.

Most CEs and SMs reported that membership of the Collaborative was worth the cost:

> "*Yes, overwhelmingly we see the value in this forum for building strong partnership. And the governance structure allows us to do that, with CEO level and ability to bring issues and priorities to that CEO forum. …. "Over time partnership activity has built good solid working relationships."*

Responses to the question however varied from "absolutely" to "yes and no." Some commented that their organisation contributed more than other partners, with others commenting on the proportion of contributions relative to the size of organisations.

There were also inconsistent responses to the question as to whether the benefits of being part of the Collaborative are equitably distributed. Some didn't think there was a significant disparity in benefits received, some were unsure and one commented that they were not equitable and that some partners were more vested in parts of the initiative. They commented on the disparity of size of the partners: "Will always have differential benefits (however) there have been benefits for all partners." It was also commented that collaborative work was core business for the Medicare Local which did not have the competing priorities of service delivery.

Most interviewees also reported that currently it did not matter if the benefits were not equitably shared – "Doesn't matter. The community's health is what matters." However it was also commented that this could become a problem in the increasingly competitive environment or where the cost/benefit became too pronounced, particularly given the significant disparity in organisational size and resource base. One CE commented that the time commitment was more of an issue than the dollars committed and another that there should be more of a discussion in the Collaborative around proportionality.

Comments included:

> *(Not a problem now) "But we do operate in a competitive environment and so long as one agency is not getting significantly more benefit than the equal partners should – that would be a problem."*
>
> *"Resourcing is also an issue in terms of relative effort and contribution as a proportion of what we are doing it is quite significant, but in terms of who they are and what they do it is much less significant."*

Interaction with partner organisations

External stakeholders were asked if the Collaborative had changed the way they interact with member organisations.

Responses to the question appeared to reflect the level of involvement in Collaborative activities. Some stakeholders stated that there had been a change in their level of understanding of what each organisation was doing. One reported that there were now different reasons for contact, while another reported only a little impact on their interaction with member organisations.

ADDRESSING THE COLLABORATIVE STRATEGIC PRIORITIES

SMs were asked how well they thought the collaborative is addressing its five strategic priorities:

1. Redesign services to improve coordination, interface and client experiences
2. Respond to the highest healthcare needs in our catchment
3. Drive a collaborative culture across our workforce
4. Embrace e-health to improve systems connections
5. Demonstrate collaborative results

Redesign services to improve coordination, interface and client experiences

Responses by SMs to the question relating to redesign of services were as follows:

- All projects have design in them.
- Limitations due to funding constraints and need for different approaches to funding - "Tough because a lack of additional resources. Been doing lots of work but…only so far you can go with harnessing the goodwill."
- "Yes through choosing small projects but how to push for more dramatic systems change still an issue."
- Mixed – "some good examples of redesign but for fundamental redesign in a primary health sense – still a little way to go."

Respond to the highest healthcare needs in our catchment

All reported that the Collaborative had responded to the data around the highest needs in the catchment.

Drive a collaborative culture across our workforce

Driving a collaborative culture was an aim that was not seen to be as developed as hoped. The CEs and the SMs groups were reported operate in a very collaborative manner as did some projects especially where there were clinical staff involved. However other staff within the partner organisations, particularly those who were not directly involved in Collaborative projects, were reported to still not generally operate collaboratively.

Comments included:

> *"Hasn't been a consistent driving of the culture and probably an area where we have done it more through the work as opposed to a strategy around how we change culture – so variable."*

> *"Could be more deliberate about the cultural stuff and how we could better utilise staff resources and HR resources across the four organisations."*

It was recognised that cultural change in the hospital was particularly difficult given its size.

Embrace e-health to improve systems connections

The e-health project was seen to be the least developed and most complex of the projects. It was also acknowledged that the project relied on work outside the Collaborative's control including the implementation of the Commonwealths patient's health care record. Comments were also made regarding the huge financial and operational requirements in e-health and the lack of financial resources that were available for the project.

Demonstrate collaborative results

Comments varied regarding the Collaborative's success in demonstrating collaborative results. The pathways and some projects were seen to have achieved some results although some commented that it was early days. Results were reported in the back pain project in particular - "been able to demonstrate being able to take people off the Melbourne Health wait list," and CKD –"been good capacity building," for example education and training provided and resources shared. "It's promising. I think what we are doing is creating a platform."

One SM commented that evidence of some project results was subjective and that it needed to be more objective and to move to demonstrating outcomes rather than structure and process results. Another questioned whether it might be better working with government to pilot different funding models and another that getting reach is hard particularly without resources.

ORGANISATIONAL CHANGE

SMs were asked in what ways their organisation and their partner organisations had changed as a result of being a Collaborative member.

In respondent's organisation

Some SMs reported that their organisation was more attuned to partnerships as a result of the Collaborative however others thought there had been little change as, "partnership is always part of how we have worked." Other comments included reference to better pathways, influence on scope of practice, that project work has built relationships (at a senior level) and that the organisation has built credibility through participation in the collaborative.

In partner organisations

SMs reported increased understanding and trust in partner organisations. In particular engagement by clinicians and building their trust was seen to be important. Although this had started to filter down through organisations, and in particular this was noted in the hospital, it was reported that this needed to continue. One SM commented that their organisation/sector are "thought of more than before" and more likely to be included in activities of their partner organisation. The importance of leadership was stressed.

PROJECTS

Process for deciding projects

CEs and SMs were asked to describe and comment on the process for selecting projects.

Most interviewees referred to an informal process after a more formal agreement on the overarching priorities for the region. There was discussion at CE and SM level to "kick it around."

Population needs and the demands on the hospital system were reported to be factors in decisions and it was also reported that some projects arose from the particular needs of a partner organisation, for example on the evidence of current avoidable admissions or a particular interest of one of the partners. One interviewee commented that it was unlikely that a project would get up if it "didn't have traction with the acute." One interviewee attributed the choice of original projects to a staff workshop.

The decision as to who would lead a project also appeared to be informally decided at the CE and SM level with one interviewee reporting that partners were "more likely to step forward than step back."

In both choosing projects and who would lead them, the process was described as pragmatic and working well: "Good part about it – we're on the same page. Not hard to get consensus" and "like a bunch of friends almost; working together. We haven't required a bureaucratic process."

CEs and SMs agreed that the collaborative did not have to respond to every opportunity that arose and that this would not be possible. Opportunities need to be discussed and assessed, and resourcing was reported to be a focus in this. There was for some a "realisation that this is additional work and we must manage the workload and agree what we can do and what we don't have the capacity to do;" and "Can't be all things to all people. Won't be able to meet expectations ….. We're conscious of the need to have boundaries." In particular, a proposal may not proceed, "when it is not necessarily a fit for all partners and potentially when the cost may be high in initiating."

Interviewees suggested that the process in future for deciding on projects should consider priorities, and focus on areas where additional resources might be available: "Can only look at the identified priorities in our catchment and then agree on the top priorities and chip away. Because that's the only way we can do it." Some commented that resources can be found internally or externally if there is a will to proceed with a particular project: "Measure of the value of the Collaborative is whether people will put money in to it." One interviewee stressed the need for advocacy to be a primary role for the Collaborative: "We in the Collaborative need to ramp up the political advocacy to say, 'listen, stop doing the same – you really need to support innovation to change the system. If you keep doing what you're doing, you'll keep getting the same results. If you keep putting the money into acute hospitals the problem doesn't get any better'." The Collaborative needed to approach government for support "to drive real and demonstrable system reform and pilots …… Let's do it and show we can do it more effectively. – clinical outcomes and cost effectively."

Using outcomes of projects

Interviewees were asked how they were using the outcomes of joint projects and the strategies and mechanisms implemented through projects to effect broader systems-level change.

It was reported that the outcomes of projects were being used to promote collaborative work with government, win tenders, increase funding opportunities, increase commitment in and upskill staff, and change practice within organisations. Workshops with clinical staff were reported, application of health pathways and consideration or implementation of the use of project models for other conditions. One interviewee stated that it depended on the project; for instance CKD had a resource kit product that will be disseminated through partner agencies.

Projects' final reports and evaluations were also reported as mechanisms that will potentially be able to be used for systems change. In addition to these, the value of the relationships and cooperation between individuals and organisations was reported to be an additional spinoff from the projects without being funded as projects: "There is a greater tendency for us to be invited to things that partners are doing. Not specific projects but other work."

Descriptions of outcomes of projects included:

> *"To drive innovation and change practice within our own organisation."*
>
> *"To promote to government the opportunities and potential of this sort of work but also evidencing that we can do it – that more than just a good idea."*
>
> *"Starting to promote them and at the cusp now of starting to drive the political agenda."*
>
> *"Highlighted to our workforce … to challenge traditional ways we manage clients or services."*
>
> *"Good for staff to see there is a different way of doing things…. Highlights that change can be a good thing and something can come out of it."*
>
> *"No question that the learning from the projects is being used to inform other work."*
>
> *"Also looking at publishing to say this gets results and this is what you need to invest in."*

SUSTAINABILITY OF COLLABORATIVE PRACTICE

Normalisation of collaboration

CEs and SMs were asked if collaboration has become "normal" practice between partner organisations yet. Some interviewees reported that collaboration had become normal practice at least to some degree, in particular at the SM and CE level: "If for instance the CEOs ceased to be as committed, or senior managers– if all the players were to change, I wonder if in some of the projects the momentum would continue. I think it is very dependent on having those structures in place and I think the individuals – or sufficient number of them."

Some progress towards ongoing collaborative behaviour was reported through the projects but this did not necessarily extend throughout the whole organisation. This was reported to be particularly the case at Melbourne Health due to its size. GPs were also still seen to be particularly hard to engage. One interviewee commented that collaboration was not seen as *normal* practice but as *expected* practice which was a start.

Several interviewees commented on disincentives created by the government to collaborate, including lack of appropriate funding models and a funding stream to support embedding a collaborative approach:

> *"The challenge is the mainstreaming of the work because it is another thing we are trying to manage. In the absence of funding models to support the work."*

> *"I think any competitive tendering process throws everything out the window." "Interferes with trust."*

CEs and SMs were also asked what "normal collaboration" would look like in this context. Responses included:

> *"The spirit of give and take is essential. Call somebody up and be heard and be taken seriously…great if seamless for the patient. That we knew what each other was doing and working to the same hymn sheet. – still a long way to go – maybe at 15% of the journey. But it's the toughest part of the journey at the start."*

> *"My observation is that the great value of the Collaborative, not just in the Collaborative but in other contexts where you are working with your acute sector colleagues, is that when the specialists and others start working with us – in our buildings, with our staff …. Much to their amazement often discover that they like us, and particularly they discover that our clinical governance is ok, and that our quality is good and that the vibe is good … and what happens is that they decide that they like it enough to try to generate greater and further work. We're beginning that process – there is a growing level of mutual respect across the interface. And it really is quite strange how it happens. They do genuinely start to go – "you folks do really run a tight ship. … Normal would be where you had that without the Collaborative framework and the chief executive driving it and oversight."*

> *"Not yet at the stage where individual clinicians or whatever from either side of the sector could initiate something and have it play out."*

> *"For me, it's about when there is a problem defined that needs a response that people would automatically say –'let's do this together, in collaboration rather than how each could individually do it – or individually compete to do it.'"*

> *"One of the things we haven't done – there aren't standard meetings of clinicians…It is still being top down driven… I think that is probably the missing part."*

"Clinicians drive part of it but it is still about projects."

"Still haven't embedded the sustainability around this should be standard business. Rather than being seen as pilots or projects. Haven't been funded to go beyond that and so haven't normalised it."

"That people regularly sit down to do brainstorming and planning before launching off into projects. And willingness to share resources."

PROMOTION OF THE COLLABORATIVE

SMs were asked how awareness of the Collaborative had been promoted in the last six months.

The annual forum was mentioned in several responses as a recent mechanisms for promotion of the Collaborative. Conference presentations, a recent article in the AHHA journal, providing information at appropriate meetings/working groups and use of internal newsletters were also mentioned. There was however a common view that more should be done to promote the Collaborative and its work, with one SM particularly referring to promotion by CEs. Videos, journal articles and the media were cited as potential avenues for promotion, together with direct approaches to government at state and federal levels. Finalisation of a Communication Plan and recent discussions around the appointment of an executive/project officer who could promote the Collaborative as part of their role, were expected to assist in promotion in the future.

RISKS TO THE COLLABORATIVE

CEs and SMs were asked what risks they could foresee for the Collaborative in the next 1-2 years.

The most common risk cited was the danger of losing momentum, particularly given the changing external environment and the internal restructuring occurring, "the whole distraction of reorganisation" and the move from Medicare Local to Primary Health Network (PHN). The PHN was seen as particularly a potential risk: "if (it) gets too distracted by the wider region and doesn't have the capacity to respond." Some however commented that the formation of the PHN was less of a risk as it would be the same core organisation, CEO and executive team as the ML. The new PHN and community health amalgamations were reported to present uncertainties around boundaries, the potential need to increase the Collaborative organisational membership, and possible changes to organisational representation to organisations and individuals with whom relationships are not established or who may not be as committed. One interviewee commented that "you achieve more if you have stable leadership".

Resourcing was reported by some to be an ongoing problem including cuts to the hospital, while others thought the move to Primary Health Networks might be more an opportunity around commissioning for establishing new partnerships and opportunities to access resources, rather than a risk. Other risks reported included difficulties maintaining focus and overstretching.

It was reported that risks could be reduced by ensuring commitment keeps up, good communication continues and that the achievements of the Collaborative and the economic case for systems change continue to be put. Other proposals were making sure the Collaborative meets not only patient's needs but the needs of the collaborative partners.

Comments included:

"That it loses momentum."

"That we aren't able to respond to the workload associated with it."

"Potentially that the impediments with funding will prevent the desired innovation."

"Competitive tension between community health a great risk to being able to sit around the table and share openly and try to get co- investment."

"There is a risk in the transition to PHNs that we can't do everything or that the quality of it diminishes a bit because our attention starts to focus elsewhere."

"There will be a need to transition a lot of current ML programs and services in those other areas which will occupy a lot of the time of the executive around how that process works. … We don't want to drop the ball in that process…. We'll be stretched."

"If you get someone who isn't a team player that could jeopodise the whole thing…. If they haven't been part of the original group – how will they feel loyalty, trust and buy in to the greater good of the collaborative – so far done on trust and not financial input."

"Also a constant risk for all of us is how you manage GPs. (It's a) chronic risk in managing this integration all over the world. ….. A major issue in terms of transforming health is that they are managed. Was same in the NHS."

SUGGESTIONS TO STRENGTHEN THE COLLABORATIVE

Other stakeholders were asked if there were things that the Collaborative could be doing differently or better.

Stakeholders made a number of suggestions including:

- Improving communication with staff and others regarding the Collaborative – "Communication is a challenge."
- Having a strategic driver – a paid person "everyone is currently squeezing it into everyday business."
- Think strategically about where it will fit with the new PHN.
- Consider broader representation.
- Keep doing things and keep leadership.
- Embed into practice and sustain.
- Beware of too many projects and overstretching resources and focus.
- Look at opportunities for research grants through universities.

ADVICE TO OTHERS ESTABLISHING A COLLABORATION

All CEs and SMs had a positive message and advice to others thinking of setting up a collaborative like INWMHC. Commitment and vision by CEOs was important and their ongoing involvement, as was the engagement of clinicians. An executive and "a few others" are also needed to do the "nuts and bolts." Documented governance structures, an evaluation process and a space to have difficult conversations were also recommended. Pursuing a few things that will get outcomes and build credibility, trust and staff engagement were also reported to be important as was ensuring the collaborative adds value to the relationships. One interviewee commented that all community health services should be involved in a collaborative.

Comments included:

"Do it!"

"I'd say this is a really worthwhile enterprise…. Make sure you're very realistic upfront about the time and the resources and the commitment that will go to putting it in place. Be really clear about the roles and expectations of partner members – which I think we've done. We articulated that through the framework agreement that starts us off."

"Consider all or any other funding opportunities from the start rather than thinking you can carry this with your own internal resources."

"Be in it for the long haul!"

"Where you don't have good structures and processes then what asserts itself is pre-existing power structures."

"What has benefitted this work is detailed planning and clarity of expectations and process."

"Be confident to go forward without counting the nickels and dimes. You've got to have a belief that it's the right thing to do and not fuss about the minor details."

"Flexibility and trust – have to trust that it is the right thing to do and that the benefits will accrue if you pursue it."

"Nothing can be completely fore seen. It's about being flexible and resilient and riding the waves up and down."

"Acknowledging the money isn't everything but is how you articulate skin in the game. It might be in kind or whatever but making sure clear from upfront….. Communication is key in all that. Making sure that the processes that are in place are mutually reinforcing the needs of the various stakeholders and deliver positive movement – no point in collaborating for the sake of collaboration."

"Some of what we deal with is real lump in your throat stuff and the impact on people's lives. … Sector been traditionally passive - not out there saying look at me, look at me and at the great work we are doing! The average person on the street probably doesn't know what a community health centre does."

"Maybe need to ramp up political advocacy agenda more to try to bring about some changes that we are seeking." "Not something overt or inherent in the Collaborative. So maybe something that we need to focus our attention to more."

OTHER COMMENTS

Interviewees commented on the effectiveness of the collaborative and how well it works. The collaborative was described as not perfect but that it has the right structures to progress. It needs to engage clinicians as champions and continue to show what it value-adds. It was suggested that the move from projects to systemic change will come through innovative funding models and pressure should be put on government to develop these.

It needs to be recognised that collaborative members will not all be equal partners in size and for some partners developing a collaborative approach will be their core business but this will not be the case for other

partners, however this should not preclude working on a shared agenda. Partner commitment is essential and the individuals involved make a difference.

One interviewee commented that there was a need to understand that working collaboratively is still an unusual way to work and that the Collaborative should focus more on articulating to others and government what it does and the advantages.

Other comments included:

> *"We are in a time of risk and opportunity. Need to nurture and develop the work that we've begun."*
>
> *"If you're not fully committed you can't do any of this work."*
>
> *"Still held together and that is a significant achievement really."*
>
> *"The Collaborative have had some amazing successes."*
>
> *"Been fantastic having an opportunity to connect the acute hospital and some of the acute staff with the community because often don't have any reason to go out there.*

CONCLUSION

Achievements

There continues to be a strong sense of commitment and enthusiasm from key stakeholders about the INWMHC, particularly with those more closely involved. The Collaborative continued to build trust and understanding between members and an ongoing strong relationship between the partners in spite of the changing and increasingly competitive context within which it is operating. This was reported to be the Collaboratives main achievement. The Collaborative is seen as providing a platform on which to continue to build improvements to service delivery and ultimately improve client outcomes. Satisfaction with what was commonly described as an informal process for deciding projects and who leads them, could be seen as an illustration of the trust that has been established, at least at higher levels across member organisations. It was reported that the achievements of the Collaborative would not have been delivered at least to the same extent, without the Collaborative structure. The development of clinical pathways and the back pain clinic and diabetes projects in particular were given as examples of tangible achievements to date. Although some commented that collaborative results would take time and are more likely to be seen in the future, others commented that there should now be more of a focus on measurable outcomes and the promotion of these.

Overall the Collaborative was reported to have addressed its strategic priorities, although less so regarding e-health, mainly due to the difficulty of the task and external circumstances beyond the Collaborative's control. There was also a view that more could be done to demonstrate the results of the Collaborative's work, particularly to government, to encourage more innovative funding models.

Considerations

The proposed employment of a dedicated worker to the Collaborative should assist in promoting the achievements of the Collaborative and the value of a collaborative model more generally, to government and stakeholders from the acute and primary health care sectors. Measurable outcomes and cost benefit analyses will be an important part of this, and essential in advocating with government for alternative funding models to support collaborative activity. Promotional opportunities should be pursued, including in the media to

increase community understanding and confidence in the value of relocating appropriate services into the community if appropriate resourcing is provided.

Resourcing

Overall, participation in the Collaborative is perceived to be worth the cost. There were however inconsistent responses regarding distribution of benefits and equity of contributions. Although there seems to be less concern than in 2014 that the benefits may not be equally shared, there is still some concern that contributions of resources are unequal and in particular that they are not proportional to perceived capacity. That ultimately the Collaborative is for the benefit of consumers rather than individual organisations is recognised and the aim to move services from the acute to primary sectors is strongly supported by all stakeholders.

Considerations

Difficulties with resourcing Collaborative activities are unlikely to lessen and there is potential for resourcing issues to create tensions within the Collaborative in the future and jeopardise existing relationships. It would be timely for Collaborative members at SM and CE levels to have a frank discussion to air concerns regarding disproportionate contributions before these grow. Where services are to be relocated from the acute sector into the community, it would be reasonable for the resources required to also be transferred. This may require renegotiation of funding agreements or it may be possible through in kind arrangements.

System change

Collaboration is not yet seen as normal practice within partner organisations other than at SM and CE levels although this was reported to be improving. It was recognised that the normalisation of collaborative practice would take time, particularly in large organisations and where this had not previously been part of the organisational culture. It was reported that normalisation would be identified by a range of indicators including that responses to issues arising would include suggesting working on solutions together, sharing resources and information and high levels of clinician interaction between organisations, particularly when self-generated and including relocation where appropriate. The Collaborative is yet to achieve the aim of system change however a number of examples were given of mechanisms that stakeholders considered would assist including continuing building relationships particularly between clinicians, workshops involving clinical staff from different member organisations, resource development, application of health pathways and consideration or implementation of the use of project models for other conditions. Translation of project learnings into systems level change through consideration of project final reports and evaluations were also reported as mechanisms that will potentially be able to be used for systems change.

Considerations

The Collaborative ultimately aims for systems change; however, although there were some suggestions for how normalised collaborative practice would look and what might contribute to it, it remains unclear how the transition from successful project work to systems change will be undertaken. This needs to be a focus at SM and CE level. It is likely that this will involve difficult decisions when service transition to the community is completed, including potentially who should be resourcing what services in the long term, permanent staff relocations or withdrawal of (specialist clinical) staff and possibly cessation of some existing services in the acute sector. The timing of such changes needs to ensure that clinical competency and trust between practitioners from both sectors has been adequately established.

Risks

The most common risk reported for the Collaborative was the danger of losing momentum, particularly given the changing external environment and the internal restructuring occurring. The creation of the PHN in particular was seen by most as a risk given the larger catchment and potential for membership of new organisations and/or representation where trust and commitment may not have been established. The Collaborative needed to be careful not to overstretch itself and it could not respond to all opportunities. Resourcing was also seen to be an ongoing issue. Maintaining commitment, ensuring good communication continues and promoting the achievements of the Collaborative and the economic case for systems change were some mechanisms suggested to offset future risks.

Considerations

It will be important for the CEs and SMs to continue to meet regularly to progress the Collaborative agenda. Inducting any new individuals joining leadership roles and ensuring communication continues to be effective between partners and externally, will be essential. Full and frank communication will also be important to consider funding constraints and any changes to government policy that may impact on the Collaborative. The creation of the PHN in place of the ML will be a risk and potentially an opportunity. Discussions should encourage support of the current Collaborative and the collaborative model more generally.

Advice to others

All those interviewed were encouraging of others potentially interested in establishing a collaborative. Advice tended to focus on understanding the time and commitment involved, and stressed the importance of structures, processes and documentation to ensure clear understandings of aims and expectations. Starting with “low hanging fruit” and promoting achievements to build credibility and commitment were also seen as important.

Results: Strength of Partnership Survey (for governance groups)

METHOD

Participants

Each interviewee participating in key stakeholder interviews and in project group interviews was invited to complete a survey reflecting on the characteristics of the governance group with which they were involved.

In 2015, there were at least two respondents for each governance group (Table 1). There was a reasonably even spread in the number of respondents from each member organisation, ranging from 2 (cohealth formerly Doutta Galla CHC) to 8 (Melbourne Health) in 2014 (Time 1), and from 4 (INWM Medicare Local) to 8 (Merri CHS) in 2015 (Time 2) (Table 2).

Table 1: Governance group that is the focus of comments

Governance Group	No. responding Time 1	No. responding Time 2
CE Group	3	3
Senior Managers' Steering Group	3	2
Project management group - CKD	6	2
Project management group – Diabetes, CCC	3	6
Project management group – Back Pain	7	6
Interface & e-Health	0	5
Total	22	24

Table 2: Which organisation respondent is representing in the INWMHC

	Time 1		Time 2	
	N	%		
cohealth formerly Doutta Galla CHC	2	9.1	5	20.8
INWM Medicare Local	5	36.4	4	16.7
Melbourne Health	8	22.7	7	29.2
Merri CHS	7	31.8	8	33.3

Measuring Characteristics of Collaboration

Seventeen questions explored five domains of collaboration reflected in a theory of collaboration proposed by Thomson et al., (2007): governance, administration, autonomy, mutuality and norms (trusts). Thomson et al. define collaboration as a multidimensional, variable construct composed of five key dimensions, two of which are structural in nature (governance and administration), two of which are social capital dimensions (mutuality and norms), and one of which involves agency (organizational autonomy).

- Governance is described by Thomson et al. (2007) as ***understanding how to jointly make decisions about rules that will govern the behavior and relationships within the collaboration.***

- Administration is about ***establishing an effective operating system for collaboration*** that includes "clarity of roles and responsibilities, communication channels that enhance coordination, and mechanisms to monitor each other's activities in relation to roles and responsibilities".
- Autonomy captures the idea that ***partners have to maintain their distinct identities and authority separate from the collaboration*****:** "This reality creates an intrinsic tension between organizational self-interest—achieving individual organizational missions and maintaining an identity distinct from the collaborative—and a collective interest—achieving collaboration goals and maintaining accountability to collaborative partners and their stakeholders".
- Mutuality reflects the notion that the ***partners are interdependent:*** "Organizations that collaborate must experience mutually beneficial interdependencies based either on differing [complementary] interests…or on shared interests—usually based on homogeneity or an appreciation and passion for an issue that goes beyond an individual organization's mission".
- Norms reflect the idea tha**t *organisations will be motivated by reciprocal obligation, and that trust has to be built over time.*** Thomson et al., note that "partners may be willing to bear disproportional costs at first because they expect their partners will equalize the distribution of costs and benefits over time out of a sense of duty". As a collaboration matures, there should be less of an "I-will-if-you-will" or tit-for-tat approach.

Respondents to the survey indicated to what extent "the partner organisations engage in the following behaviours or exhibit the following attitudes", where "the collaboration" referred to "the governance group that you are involved with".

Questions were responded to on a scale from 1 "not at all" to 6 "to a great extent" for most items and 1 "disagree strongly" to 6 "agree strongly" for some items, in accordance with Thomson, Perry & Miller (2007). A "don't know" option was also included. The distribution of scores is shown in Table 3.

A mean score was calculated for each question. The mean indicates where on average on the scale of 1 to 6 the respondents think the governance group is. The standard deviation (SD) is also provided (Table 3). This gives an indication of the spread of the responses, which in turn reflects the degree of consistency in the beliefs or attitudes of respondents. For example, for question 4, a mean of 5.0 and SD of 1.0 (2015) indicates that, on average, respondents thought the governance group they were involved with was approximately 5 on the 1-6 scale, and most people responded within 4 and 6. This pattern is confirmed by looking at the distribution of the number of responses over the 1-6 scale in Table 3.

RESULTS

Characteristics of governance groups

All of the means for the strength of collaboration questions at both times indicated that the majority of respondents thought the governance group in which they were involved had positive characteristics and demonstrated positive attitudes and behaviours.

That is, in 2015, respondents continued to **strongly endorse** the view that the governance group with which they were involved **had positive characteristics and demonstrated positive attitudes and behaviours.**

Table 3: Assessment of collaboration within the governance group

		Mean (SD)	Not at all 1	2	3	4	5	To a great extent 6	Don't know 9
GOVERNANCE									
1. Partner organisations take your organisation's opinions seriously when decisions are made about the collaboration.	2014	5 (0.8)				6 (27.3)	9 (40.9)	7 (31.8)	
	2015	5.4 (0.8)				4 (16.7)	7 (29.2)	13 (54.2)	
2. Your organisation brainstorms with partner organisations to develop solutions to mission-related problems facing the collaboration.	2014	4.9 (0.8)				8 (36.4)	9 (40.9)	5 (22.7	
	2015	5.0 (0.7)			1 (4.2)	3 (12.5)	14 (58.3)	5 (20.8)	1 (4.2)
ADMINISTRATION									
3. You, as a representative of your organisation in the collaboration, understand your organisation's roles and responsibilities as a member of the collaboration.	2014	4.9 (0.8)			1 (4.5)	5 (22.7)	11 (50)	5 (22.7)	
	2015	5.3 (0.8)			1 (4.2)	1 (4.2)	12 (50.0)	10 (41.7)	
4. Partner organisation meetings accomplish what is necessary for the collaboration to function well.	2014	4.5 (0.9)		1 (4.5)	1 (4.5)	8 (36.4)	10 (45.5)	2 (9.1)	
	2015	5.0 (1.0)		1 (4.2)		5 (20.8)	11 (45.8)	7 (29.2)	
5. Partner organisations (including your organisation) agree about the goals of the collaboration.	2014	5.1 (0.9)			1 (4.5)	5 (22.7)	6 (27.3)	9 (40.9)	1 (4.5)
	2015	5.0 (1.0)		1 (4.2)		4 (16.7)	11 (45.8)	8 (33.3)	
6. Your organisation's tasks in the collaboration are well coordinated with those of partner organisations.	2014	4.7 (0.9)			2 (9.1)	7 (31.8)	9 (40.9)	4 (18.2)	
	2015	4.9 (0.8)			1 (4.2)	5 (20.8)	13 (54.2)	5 (20.8)	
AUTONOMY									
7. The collaboration hinders your organisation from meeting its own organisational mission. (RS for mean; distribution not reversed)	2014	4.2 (0.9)	11 (50)	5 (22.7)	4 (18.2)	1 (4.5)			
	2015	5.4 (1.1)	16 (16.7)	3 (12.5)	4 (16.7)		1 (4.2)		
8. Your organisation's independence is affected by having to work with partner organisations on activities related to the collaboration. (RS)	2014	4.1 (0.7)	7 (31.8)	11 (50)	4 (18.2)				
	2015	5.1 (1.2)	12 (50.0)	7 (29.2)	2 (8.3)	2 (8.3)	1 (4.2)		
9. You, as a representative of your organisation, feel pulled between trying to meet both your organisation's and the collaboration's expectations. (RS)	2014	3.2 (1.5)	6 (27.3)	3 (13.6)	7 (31.8)	3 (13.6)	2 (9.1)	2 (4.5)	
	2015	4.9 (0.8)	4 (16.7)	15 (62.5)	3 (12.5)	2 (8.3)			
MUTUALITY									
10. Partner organisations (including your organisation) have combined and used each other's resources so all partners benefit from collaborating.	2014	4.1 (0.9)		1 (4.5)	4 (18.2)	10 45.5)	5 (22.7)	1 (4.5)	1 (4.5)
	2015	5.1 (0.9)			2 (8.3)	1 (4.2)	13 (54.2)	8 (33.3)	
	2014	4.7 (0.8)			1 (4.5)	8 (36.4)	10 (45.5)	3 (13.6)	

		Mean (SD)	Not at all					To a great extent	Don't know
11. Your organisation shares information with partner organisations that will strengthen their operations and programs	2015	5.3 (0.8)			1 (4.2)	3 (12.5)	9 (37.5)	11 (45.8)	
12. You feel what your organisation brings to the collaboration is appreciated and respected by partner organisations.	2014	4.9 (1.0)		1 (4.5)	5 (22.7)	10 (45.5)	6 (27.3)		
	2015	5.4 (0.7)				3 (13.6)	8 (36.4)	11 (50.0)	
13. Your organisation achieves its own goals better working with partner organisations than working alone.	2014	4.6 (1.1)		1 (4.5)	2 (9.1)	5 (22.7)	7 (31.8)	4 (18.2)	3 (13.6)
	2015	5.5 (0.6)				1 (4.2)	11 (45.8)	12 (50.0)	
14. Partner organisations (including your organisation) work through differences to arrive at win–win solutions	2014	4.6 (0.7)				10 (45.5)	9 (40.9)	2 (9.1)	1 (4.5)
	2015	5.0 (0.7)				5 (20.8)	12 (50.0)	6 (25.0)	1 (4.2)
			Strongly Disagree	Moderately disagree	Disagree Slightly	Agree Slightly	Moderately Agree	Strongly Agree	Don't know
			1	2	3	4	5	6	9
NORMS									
15. The people who represent partner organisations in the collaboration are trustworthy.	2014	5.6 (0.7)				2 (9.1)	4 (18.2)	16 (72.7)	
	2015	5.6 (0.8)				5 (20.8)		19 (79.2)	
16. My organisation can count on each partner organisation to meet its obligations to the collaboration.	2014	4.7 (0.9)		1 (4.5)	1 (4.5)	4 (18.2)	13 (59.1)	3 (13.6)	
	2015	5.0 (1.0)		1 (4.2)		6 (25.0)	7 (29.2)	9 (37.5)	1 (4.2)
17. Your organisation feels it worthwhile to stay and work with partner organisations rather than leave the collaboration.	2014	5.4 (0.8)				5 (22.7)	4 (18.2)	13 (59.1)	
	2015	5.8 (0.5)				1 (4.2)	2 (8.3)	21 (87.5)	

RS = Reverse scored [Strongly Disagree = 6 for these items when creating a mean and total scale score. A high score always indicates a positive characteristic of or attitude towards the partnership. HOWEVER, the distribution has not been reversed.]

Comparing characteristics over time and for different groups

Thomson et al. describe five sub-scales within the 17 item questionnaire, measuring different aspects of the collaboration:

- Governance (2q – Q1, Q2)
- Administration (4q – Q3 to Q6)
- Autonomy (3q – Q7 to Q9)
- Mutuality (5q – Q10 to Q14)
- Norms (Trust) (3q – Q15 to Q17)

To enable comparisons of the views of respondents in different governance group and/or on the basis of the respondent's organisation, a score for each sub-scale score was created. Responses to the "autonomy" questions (q7-9) were reverse-scored so that all high scores indicate a positive characteristic.

Reliability analysis for each of the subscales showed a Cronbach's alpha ranging from 0.65 (2 item governance sub-scale) to 0.90 (5 item mutuality sub-scale) in 2014 and 0.53 (3 reverse item autonomy sub-scale) to 0.87 (4 item administration sub-scale) in 2015.

- Comparison of the means of each of the subscale total scores from 2014 to 2015 indicated that the ratings of "mutuality" had increased significantly from 2014 to 2015 (21.8 to 25.6, $p<0.001$).
- The mean overall total score was also significantly higher in 2015 compared with 2014 (77.8 compared with 72.7, $p<0.02$).
- Analysis of the sub-scale scores confirmed that there was NO significant difference between the mean scores of respondents from different governance groups in 2014 or 2015. This indicates that all groups are seen to be operating equally well.
- Similarly, comparison of mean scores when respondents were grouped according to the sector they represent (Community Health, Acute, General Practice) indicated no significant differences on any of the sub-scales in 2014 or 2015. This indicates that the perspectives of respondents was not associated with the sector they represented.

Demonstration of INWMHC Foundation Principles

In addition to the theoretically-based questions about collaboration, six questions explored interviewees' views of the extent to which their own organisations' behaviours and attitudes reflected the stated foundational principles of the INWMHC, and six questions explored perceptions of the behaviour and attitudes of partner organisations.

The means for these items indicated very high levels of consistency of behaviour and attitudes with the foundational principles of the INWMHC by respondents' own organisations (means 5.0-5.7 in 2014 & 5.1-5.6 in 2015) (Table 4).

Table 4: Extent to which respondent's organisation is demonstrating attitudes & behaviours reflecting foundational principles

Your organisation…		Mean (SD)	Strongly Disagree 1	Moderately disagree 2	Disagree Slightly 3	Agree Slightly 4	Moderately Agree 5	Strongly Agree 6	Don't know 9
Is committed to the partnership and is actively participating in the collaboration	2014	5.7 (0.7)				2 (9.1)	4 (18.2)	16 (72.7)	
	2015	5.6 (0.6)				1 (4.2)	7 (29.2)	16 (66.7)	
Recognises the strengths, culture and voice of other partners in making decisions	2014	5.3 (0.6)				2 (9.1)	11 (50)	9 (40.9)	
	2015	5.5 (0.7)				3 (12.5)	6 (25.0)	15 (62.5)	
Shares information and ideas to support and strengthen collaborative projects, programs and processes	2014	5.4 (0.6)				2 (9.1)	10 (45.5)	10 (45.5)	
	2015	5.5 (0.7)				3 (12.5)	5 (20.8)	16 (66.7)	

Your organisation…		Mean (SD)	Strongly Disagree 1	Moderately disagree 2	Disagree Slightly 3	Agree Slightly 4	Moderately Agree 5	Strongly Agree 6	Don't know 9
Values and respects independence within the partnership, recognising contributions and acknowledging the strengths of partners	2014	5.2 (0.7)				4 (18.2)	10 (45.5)	8 (36.4)	
	2015	5.6 (0.7)				2 (8.3)	6 (25.0)	16 (66.7)	
Has equal standing in the partnership and is equally responsible for the outcomes of the partnership and the health of the community	2014	5.0 (1.1)		1 (4.5)		6 (27.3)	6 (27.3)	9 (40.9)	
	2015	5.1 (1.2)		1 (4.2)	2 (8.3)	3 (12.5)	6 (25.0)	12 (50.0)	
Learns from partners and incorporates learning, communications and knowledge-sharing into the relationship	2014	5.0 (0.8)				8 (36.4)	7 (31.8)	7 (31.8)	
	2015	5.3 (0.7)				3 (12.5)	11 (45.8)	10 (41.7)	

The means for opinions about the extent to which partner organisations were reflecting the principles of the INWMHC were slightly lower overall than means for the respondents' own organisation, and were more consistent, but were still clearly around the positive "moderately agree" scale point in both 2014 and 2015 (Table 5Table 6).

Table 5: Extent to which partner organisations are perceived to be demonstrating particular attitudes & behaviours

Partners in the Collaboration…		Mean (SD)	Strongly Disagree 1	Moderately disagree 2	Disagree Slightly 3	Agree Slightly 4	Moderately Agree 5	Strongly Agree 6	Don't know 9
Are committed to the partnership and actively participating in the collaboration	2014	5.1 (0.8)				5 (22.7)	9 (40.9)	8 (36.4)	
	2015	5.2 (1.1)		1 (4.2)	1 (4.2)	3 (12.5)	6 (25.0)	12 (50.0)	1 (4.2)
Recognise the strengths, culture and voice of other partners in making decisions	2014	5 2 (0.7)				3 (13.6)	12 (54.5)	7 (31.8)	
	2015	5.2 (1.1)		1 (4.2)	1 (4.2)	3 (12.5)	6 (12.5)	13 (54.2)	
Share information and ideas to support and strengthen collaborative projects, programs and processes	2014	4.9 (1.0)		1 (4.5)		6 (27.3)	9 (40.9)	6 (27.3)	
	2015	5.1 (1.1)		1 (4.2)		6 (25.0)	5 (20.8)	12 (50.0)	
Value and respect independence within the partnership, recognising contributions and acknowledging the strengths of partners	2014	5.1 (0.9)			1 (4.5)	4 (18.2)	8 (36.4)	8 (36.4)	1 (4.5)
	2015	5.2 (1.0)			2 (8.3)	4 (16.7)	5 (20.8)	13 (54.2)	
Have equal standing in the partnership and are equally responsible for the outcomes of the partnership and the health of the community	2014	4.8 (1.1)		1 (4.5)		9 (40.9)	4 (18.2)	8 (36.4)	
	2015	5.1 (1.1)		1 (4.2)	1 (4.2)	4 (16.7)	7 (29.2)	11 (45.8)	
	2014	5.0 (0.7)				6 (27.3)	10 (45.5)	5 (22.7)	1 (4.5)

Partners in the Collaboration…		Mean (SD)	Strongly Disagree 1	Moderately disagree 2	Disagree Slightly 3	Agree Slightly 4	Moderately Agree 5	Strongly Agree 6	Don't know 9
Learn from partners and incorporate learning, communications and knowledge-sharing into the relationship	2015	5.2 (1.1)		1 (4.2)	1 (4.2)	3 (12.5)	6 (25.0)	13 (54.2)	

Comparing adherence to foundational principles over time and for different groups

Two scales were created by summing the responses to the questions in each of the sets of six questions.[1]

The correlation between the two sets of questions as scales was high 0.52 (p=0.01), indicating that people had similar views about the extent to which their own and partner organisations were reflecting the foundational principles of the collaborative.

- Comparison of mean scores when respondents were grouped according to the sector they represented (Community Health, Acute, General Practice) indicated no differences in respondents' views about the extent to which their own organisation or partner organisations were demonstrating the foundational principles in 2014 or 2015.
- There were no differences comparing views for respondents from different governance groups in 2014 or 2015.
- There was no significant differences in the responses to the questions from 2014 to 2015, indicating that respondents continued to believe that their own and partner organisations were demonstrating attitudes and behaviours consistent with the INWMHC's foundational principles.

Summary

In 2015, respondents continued to **strongly endorse** the view that the governance group with which they were involved **had positive characteristics and demonstrated positive attitudes and behaviours.** The responses to the Thomson et al. governance questions suggest that the groups are continuing to operate very well. Participants in the different governance groups considered that the group with which they were involved is displaying positive characteristics in relation to domains of governance, administration, autonomy, mutuality and Norms/Trust. These characteristics all contribute to effective functioning of the governance groups and the Collaborative as a whole.

Respondents also reflected very positive opinions about the extent to which their own and the partner organisations reflect the Foundation Principles of the Collaborative in their behaviour and attitudes. This had not changed from 2014 to 2015.

While all means were high, in 2014 it was suggested that the Collaborative should monitor and discuss the potential conflict between meeting and balancing the needs and expectations of the collaborative at the same time as those of each individual organisation. This was based on the observation of a significant difference between respondents from the medicare local and others (ML respondents were more positive than others,

[1] The reliability for questions about respondents' own organisation was high (Cronbach's alpha (standardized)=0.90, n=22 valid cases in 2014; Cronbach's alpha (standardized)=0.83, n=24 valid cases in 2015). The reliability for questions about partner organisations was high (Cronbach's alpha (standardized)= 0.93, n=21 valid cases in 2014; Cronbach's alpha (standardized)=0.96, n=23 valid cases in 2015).

although all were moderately positive). The Mutuality questions relate to the extent to which respondents perceive organisations are sharing information and resources, achieving goals through the partnership, and working through any differences. This difference was not observed in 2015; in fact, the ratings of "mutuality" increased significantly from 2014 to 2015. This is a very positive sign and suggests the Collaborative has successfully addressed any issues underlying the earlier results.

Results: Partner Organisations' Staff Survey 2014 & 2015

RESPONDENTS

Each partner organisation identified the groups of staff to be invited to complete the online survey and sent invitations to participate by email. The response rates are provided in Table 6.

Table 6: Response rates

	Time 1 – 2014			Time 2 – 2015		
	Number invited	**Number responded**	**Response rate**	**Number invited**	**Number responded**	**Response rate**
cohealth formerly Doutta Galla CHC	75	29	40%	91	32	35%
Merri CHS	70	22	31%	80	28	35%
Melbourne Health	80	32	40%	81	25	31%
Inner North West Medicare Local	8	5	63%	9	4	44%
	233	**88**	**38.2%**	**261**	**89**	**34%**
Other		**1**			**1**	

In 2014, an additional 37 staff working in the HARP program across the region were invited to participate. One respondent completed the survey from this category. Their response is included in the results reported for 2014, but not counted in the calculation of the response rate above. Similarly, in Time 2 there was one respondent outside of the 4 listed partner organisations whose data has been included, although they are not included in the calculation of the response rate.

Respondent Description

There were reasonable distribution of respondents across the four organisations (Table 7), with respondents coming from a range of different areas/units/programs (Table 8). Just over half of the respondents described their role in the organisation as "clinician", with a wide range of professions and areas of practice reflected (Table 9). In 2015, about one-fifth of respondents had been working in the inner North-West Melbourne region between 5-10 years, and 28% had worked in the area for more than 10 years (Table 10). The distribution was similar to that observed in 2014.

Table 7: Organisation for which respondents work

	Time 1 – 2014		Time 2 – 2015	
Organisation	**N**	**%**	**N**	**%**
cohealth formerly Doutta Galla CHC	29	32.6	32	35.6
Merri CHS	22	24.7	28	31.1
Melbourne Health	32	36	25	27.8
Inner North West Medicare Local	5	5.6	4	4.4
Other	1	1.1	1	1.1
Total	**89**	**100**	**90**	**100**
Other (please specify): cohealth formerly NYCH (time 1) and INWMML (time 2)				

Table 8: Area/unit/program in which respondents work (open-ended responses categorised)

2014			
	N		**N**
Allied Health (including outreach)	4	Clinical / medical / gastro/ nephrology / pharmacotherapy	11
Intake	5	Diabetes	5
Clinical and Aged/Aged/chronic & aged	7	Management, Board, Executive	6
HARP	12	Primary Health Care	10
EADC	5	VIDS	2
Quality	2	One each; RMH, MCC	2
One each of: Podiatry, Liaison, outpatients, pain management, independent living, chronic, counselling	7	Niddrie Better Health Team	4
		One each of: IT, service, activities	2
2015			
	N		**N**
Allied Health (including outreach)	4	Clinical / medical / gastro/ nephrology / pharmacotherapy/ED / nursing	13
Intake	2	Diabetes	8
Child, youth, family, aged	3	Management, Board, Executive	5
HARP	9	Primary Health Care	12
EADC		Independent living team	2
Quality	1	One each; RMH	
One each of: carer links, community partnerships, outpatients, pain, quality	5	Niddrie/Kensington Better Health Team	18
		One each of: IT, projects, research, service access	4

Table 9: Role in organisation

	Time 1 – 2014		**Time 2 – 2015**	
	N	**%**	**N**	**%**
Senior executive/manager	8	9.2	6	6.7
Program manager	11	12.6	15	16.7
Project worker	1	1.1	2	2.2
Administration/Support	5	5.7	2	2.2
Consumer				
Clinician (please specify)	49	56.3	57	63.3
Diabetes Educator, co-management service	4		5	
Dietitian	3		1	
Gastroenterologist	2		0	
GP, primary health care & coordinated care	3		9	
Infectious diseases	2		0	
Intake worker	4		1	
Nurse	6		12	
OT	7		4	
Pharmacist	1		0	
Pain management	1		1	
Physiotherapist	4		1	
Podiatrist	6		0	
Speech Pathologist	1		0	
Breast surgery	1		0	
Care coordination			3	
Medical, Director emergency medicine, Anaesthetist, nephrology, clinical directorate, perioperative, outpatients, renal			8	
Other (please specify)	13	14.9	5	5.7
2014: AHA, Board Director, Activity worker, Team leader, care coordinator, liaison, manager				
2015:Board Director, chronic heart failure, projects, quality, service access, practice leader				

Table 10: Period of working in the region (inner North-West Melbourne)

	Time 1 – 2014		Time 2 – 2015	
Period	**N**	**%**	**N**	**%**
Less than 12 months	18	20.2	12	13.3
1-2 years	7	7.9	12	13.3
2-5 years	19	21.3	22	24.4
5-10 years	19	21.3	17	18.9
More than 10 years	26	29.2	25	27.8
	89	**100**	**90**	**100**

Familiarity with INWHMCH

As intended, in addition to gathering feedback from people involved in the work of the Collaborative, the survey collected responses from staff who did not know a lot about INWMHC in both years (34% and 28% respectively), and some who had not heard of the Collaborative at all (20% in 2014, but only 6% in 2015) (Table 11). Awareness of the specific activities of the INWMHC was greatest in relation to the Diabetes Project and the Chronic Kidney Disease project in 2014, reflecting that these were the two earliest projects undertaken by the Collaborative (Table 12Table 13). In 2015, a greater proportion of respondents was aware of the different projects, ranging from 45% for the ICT project to 82% for the Back Pain Project.

In 2014, most survey respondents (62%) said they had not been directly involved with activities undertaken by the Collaborative (Table 13). Those who had been involved described being involved in working parties and projects, as well as attending the Annual Collaborative Forum.

In 2015, a greater proportion of the survey respondents reported they had been directly involved in activities undertaken by the Collaborative (53%), with most people indicating they were involved in a number of activities.

Table 11: Level of awareness of the INWMHC

	N	%	N	%
Yes, I've heard of it, and I know a bit about it	39	43.8	57	65.5
Yes, I've heard of it, but I don't know much about it	30	33.7	24	27.6
No I haven't heard of it	18	20.2	5	5.7
I'm not sure	2	2.2	1	1.1
Missing			11	

Table 12: Level of awareness of the projects and activities undertaken by INWMHC

Time 1 – 2014	Yes		No		Not sure	
	N	%	N	%	N	%
Diabetes Demonstration Project (known as CCC4D, managed by INWM ML)	47	52.8	39	43.8	3	3.4
Inner North West Chronic Kidney Disease Project (CKD) Renal Project	48	53.9	38	42.7	3	3.4
ICT interface and eHealth Project	38	42.7	40	44.9	11	12.4
Project to develop a Regional Health Plan for the INWM HC	27	30.3	51	57.3	11	12.4
Health Pathways for Back Pain Project – to develop clinical pathways	40	44.9	43	48.3	6	6.7

Time 2 – 2015	Yes		No		Not sure	
	N	%	N	%	N	%
Diabetes Demonstration Project (known as CCC4D, managed by INWM ML) N=86	58	67.4	21	24.4	7	8.1
Inner North West Chronic Kidney Disease Project (CKD) Renal Project N=87	64	73.6	16	18.4	7	8.0
ICT interface and eHealth Project N=86	39	45.3	34	39.5	13	15.1
Project to develop a Regional Health Plan for the INWM HC N=85	29	34.1	38	44.7	18	21.2
Health Pathways for Back Pain Project – to develop clinical pathways N=87	71	81.6	10	11.5	6	6.9
Advance Care Planning project (Time 2 only) N=87	60	69.0	17	19.5	10	11.5

Table 13: Involvement in the projects and activities undertaken by INWMHC

Time 1 – 2014						
	Yes		No		Not sure	
	N	%	N	%	N	%
	33	37.1	55	61.8	1	1.1
(Please describe your involvement briefly)						
Annual Collaborative Forum					9	
Workshops, PD (attending and presenting)					4	
Working parties, project working groups					17	
Related project work					2	
Attended launch, involvement at all levels, oversight groups					4	
Time 2 – 2015						
	Yes		No		Not sure	
	N	%	N	%	N	%
The complexity of responses in 2015 made it difficult to count types of activities respondents were involved with. Many had attended community forums; many were on project working groups or involved in managing projects; many described involvement in project activities.	46	52.9	38	43.7	3	3.4

FEEDBACK ABOUT WORKING RELATIONSHIPS ACROSS PARTNER ORGANISATIONS

Relationships with GPs in the INWM Region

In 2014, nearly two-thirds of the respondents (65%) said they had had some professional contact with GPs in the region in the past 6 months (Table 14). In 2015, 70% said they had had some professional contact with GPs.

Those who reported having contact with GPs were directed to a set of five questions about the nature of their working relationships. Those who reported no contact were directed to an open-ended question asking if they had any comments to make about the nature of the relationships with GPs and health professional in their organisation. Respondents who completed the set of five questions also had the opportunity to respond to the open-ended question.

The response options for the five questions ranged from “never” (scored as 1) to “all of the time” (scored as 5). The distribution of responses is provided in Table 15, as is a mean and standard deviation for each item. The mean indicates how frequently on average on the scale of 1 to 5 the respondents report each of the particular behaviours to have occurred in their experience in the past six months. The standard deviation (SD)

is also provided to give an indication of the spread of the responses, which in turn reflects the degree of consistency in the responses.

- The mean responses for the five questions about working relationships with GPs ranged from 3.0 to 3.6 in both 2014 and 2015 (SD range 0.6-0.7 in 2014 and 0.6-0.8 in 2015), indicating that most of the behaviours happened between "sometimes" and "often".
- The most frequently reported behaviour in 2015 was in relation to referrals received from GPs being consistent with organisational policies, and the least frequently reported behaviours were around timely communication by GPs and joint care planning (described as occurring sometimes at both time points).

The open-ended responses reflected mixed experiences.

- Some respondents reflected on positive relationships:
  - *Relationships are building and becoming stronger when we all understand each other's roles*
- A number of comments were related to variability – of GPs' and partner organisation's practice:
  - *Some GPs have excellent diabetes management skills and make great efforts to be informed and work collaboratively with other health services/providers. GPs that I have encountered who are involved with projects involving the INWMML are incredibly dynamic and keen to collaborate to provide the best care for their patients in the right place and the right time (whether that be with the GP, with the hospital or with community health services or other community programs like HARP). Some GPs have alarmingly suboptimal diabetes management skills and make little or no effort to become informed or to work collaboratively with other health services/providers. I'm not sure why there is a difference - I suspect it may be that they are not linked with collaborative networks like these.*
  - *The information contained within OP is varied and often irrelevant*
  - *Very few GPs respond to information sent about their client.*
  - *Some GPs are reluctant to speak to allied health…Some GPs are great and are willing to problem solve*
  - *Very few GPs respond to information sent about their client*
  - *The communication between INWM GPs and the ED clinicians is disjointed at best and this is in both directions*
- Others saw more work ahead:
  - *I think that the relationship between the acute health service could be improved with GPs. There is such a long way to go though, that it often feels insurmountable. Much of the change needs to be drive at a state/Federal health department level*
  - *Better communication between the organisations would be beneficial*
- Some suggestions were offered:
  - *As a collaborative it would be good to have a common consent form for clinical information that clinicians require from GPS. This would ensure that GP practices recognise the form and act on it.*

Table 14: Proportion of respondents reporting relationships with GPs in INWM Region

	Time 1				Time 2			
GP1: Have you had professional contact with **GPs in the Inner North West Melbourne region** over the past 6 months?	**Yes**	**%**	**No**	**%**	**Yes**	**%**	**No**	**%**
	58	65.2	31	34.8	61	70.1	26	29.9

(No missing data Time 1. 11 missing cases Time 2)

Table 15: Feedback about working relationships with GPs in INWM Region

		Mean (SD)	**Never**	**Rarely**	**Sometimes**	**Often**	**All of the time**	**Valid N**
Scoring of responses			(1)	(2)	(3)	(4)	(5)	
Communication (formal and informal) between **GPs in the INWM region** and health professionals in your organisation is timely and accurate	2014	3.4 (0.7)		4 (7.5)	27 (50.9)	21 (39.6)	1 (1.9)	52
	2015	3.4 (0.8)	1 (1.7)	4 (6.7)	28 (46.7)	22 (36.7)	5 (8.3)	60
Referrals received from **GPs in the INWM region** are in accordance with your organisation's policy for referral processes	2014	3.6 (0.6)		2 (3.8)	20 (38.5)	29 (55.8)	1 (1.9)	52
	2015	3.6 (0.8)		3 (5.3)	25 (43.9)	23 (40.4)	6 (10.5)	57
GPs in the INWM region work collaboratively (with respect and recognition for each others' respective roles) with clinicians and other health professionals from your organisation?	2014	3.2 (0.6)		5 (9.6)	30 (57.7)	17 (32.7)		52
	2015	3.3 (0.6)		4 (7.0)	32 (56.1)	20 (35.1)	1 (1.8)	57
GPs in the INWM region communicate care assessments or outcomes in a timely manner to all relevant healthcare practitioners involved in a client's care	2014	3.0 (0.6)		10 (19.2)	32 (61.5)	10 (19.2)		52
	2015	3.1 (0.7)	1 (1.7)	10 (17.2)	30 (51.7)	17 (29.3)		58
GPs in the INWM region and health professionals in your organisation plan care jointly and deliver coordinated care where it is appropriate	2014	3.0 (0.6)		12 (22.6)	31 (58.5)	10 (18.9)		53
	2015	3.0 (0.8)		16 (27.6)	25 (43.1)	17 (29.3)		58

(Note that % is calculated based on valid responses to the questions.)

Working Relationships with Merri CHS

Just under half of the respondents (47% in 2014 and 45% in 2015) said they had had some professional contact with health professionals from Merri CHS in the past 6 months (Table 16).

The response options for the five questions describing the frequency of a range of behaviours ranged from "never" (scored as 1) to "all of the time" (scored as 5). The distribution of responses is provided in Table 17, as is a mean and standard deviation for each item.

- The mean responses for the five questions about working relationships with health professionals from MCHS ranged from 3.3 to 3.6 (SD range 0.7-1.0) in 2014 and 3.6-3.8 (SD=0.9 in 2015), indicating that most of the behaviours happened between "sometimes" and "often".
- The most frequently reported behaviours in 2015 were in relation to working collaboratively (with respect and recognition for each other's respective roles) and timeline communication; the least frequently (but still more often than "sometimes") reported behaviours were around joint care planning and coordinated care delivery, communicating to all health professionals and referrals received being consistent with the organisation's policies.

There were only a couple of open-ended responses, one of which suggested there was room for improvement in communication, but recognised the shared goals and commitment to collaborative care:

- *Better feedback regarding referral outcomes. Still uncertain and not confident with the type/standard of diabetes management care provided. This is due to lack of feedback, and despite work to improve referral pathways, once a referral is sent, it's often unknown what happens from there. Not sure of the type of complex Diabetes Education services (e.g., ambulatory insulin stabilisation) that are provided - this is still vague. From my contact with CHCs in the Diabetes Demonstration Projects work - it is very evident that they are committed to collaborative care and improvements in service delivery and 'the right care at the right place and the right time' across the health provider spectrum.*

The other substantive comment was related to the positive experience of working on the back pain project:

- *The relationship between MH and MCHS in the back pain project has been extremely strong. There has been excellent communication, planning and working relationship in implementing the back project and improving patient care.*

Table 16: Proportion of respondents reporting relationships with health professionals from MCHS

	Time 1				Time 2			
MC1: Have you had professional contact with **health professionals from Merri Community Health Service (MCHS)** over the past 6 months?	Yes		No		Yes		No	
	31	47.0	35	53.0	28	45.2	34	54.8

(Note Missing =23 T1 and 36 T2 – likely to indicate "don't know". Suggests unaware of service?)

Table 17: Feedback about working relationships with health professionals from MCHS

		Mean (SD)	Never	Rarely	Sometimes	Often	All of the time	Valid N
Scoring of responses			(1)	(2)	(3)	(4)	(5)	
Communication (formal and informal) between **health professionals from MCHS** and health professionals in your organisation is timely and accurate	2014	3.5 (0.7)		1 (4.0)	12 (48.0)	11 (44.0)	1 (4.0)	25
	2015	3.8 (0.9)		1 (3.8)	10 (38.5)	9 (34.6)	6 (23.1)	26

Referrals received from **health professionals from MCHS** are in accordance with your organisation's policy for referral processes	2014	3.4 (0.8)		3 (12.0)	12 (48.0)	8 (32.0)	2 (2.2)	25
	2015	3.6 (0.9)	1 (4.0)		10 (40.0)	10 (40.0)	4 (16.0)	25
Health professionals from MCHS work collaboratively (with respect and recognition for each others' respective roles) with clinicians and other health professionals from your organisation?	2014	3.6 (1.0)		2 (8.0)	11 (44.0)	6 (24.0)	6 (24.0)	25
	2015	3.8 (0.9)		2 (7.7)	7 (26.9)	11 (42.3)	6 (23.1)	26
Health professionals from MCHS communicate care assessments or outcomes in a timely manner to all relevant healthcare practitioners involved in a client's care	2014	3.4 (0.8)		2 (8.0)	12 (48.0)	9 (36.0)	2 (8.0)	25
	2015	3.6 (0.9)		3 (12.0)	8 (32.0)	10 (40.0)	4 (16.0)	25
Health professionals from MCHS and health professionals in your organisation plan care jointly and deliver coordinated care where it is appropriate	2014	3.3 (1.0)	1 (4.0)	3 (12.0)	12 (48.0)	6 (24.0)	3 (12.0)	25
	2015	3.6 (0.9)		2 (8.0)	10 (40.0)	9 (36.0)	4 (16.0)	25

Working Relationships with Melbourne Health

More than half of the respondents (62.5% in 2014 and 64.4% in 2015) said they had had some professional contact with health professionals from Melbourne Health in the past 6 months (Table 18).

The response options for the five questions describing the frequency of a range of behaviours ranged from "never" (scored as 1) to "all of the time" (scored as 5). The distribution of responses is provided in Table 19, as is a mean and standard deviation for each item.

- The mean responses for the five questions about working relationships with health professionals from MCHS ranged from 2.9 to 3.6 (SD range 0.7-0.9) in 2014 and from 3.2 to 3.9 (SD range 0.9 to 1.1), indicating that most of the behaviours happened between "sometimes" and "often".
- The most frequently reported behaviour in 2015 was in relation to referrals received being consistent with the respondent's organisation's policy, and the least frequently ("sometimes") reported behaviour was around joint care planning and coordinated care delivery.
- There was a significant increase in the mean rating for one item: Respondents reported that health professionals from MH "communicate care assessments or outcomes in a timely manner to all relevant healthcare practitioners involved in a client's care" **more frequently in 2015** compared with 2014.

The small number of open-ended responses reflected mixed experiences.

- *A positive and opportunistic relationship for the benefit of demand and our combined communities.*
- *Hospital liaison are very responsive and helpful.*
- *Referrals from MH to OT are sometimes lacking information about health conditions, medical history and medications. This information is important for our triaging and subsequent assessments and interventions.*
- *Not many referrals from MH except "difficult mental clients" that do not turn up for appointments.*
- *The more acute City Campus is very difficult to work with. They have very limited contact and it takes a long time to get a response phone call. Some doctors working on the city campus are great though.*

Table 18: Proportion of respondents reporting relationships with health professionals from MH

	Time 1				Time 2			
MH1: Have you had professional contact with **health professionals from Melbourne Health (MH)** over the past 6 months?	**Yes**		**No**		**Yes**		**No**	
	35	62.5	21	37.5	38	64.4	21	35.6

Missing = 33 T1 and 39 T2

Table 19: Feedback about working relationships with health professionals from MH

		Mean (SD)	Never	Rarely	Sometimes	Often	All of the Time	Valid N
Scoring of responses			(1)	(2)	(3)	(4)	(5)	
Communication (formal and informal) between **health professionals from MH** and health professionals in your organisation is timely and accurate	2014	3.5 (0.7)		1 (3.1)	15 (46.9)	14 (43.8)	2 (6.3)	32
	2015	3.6 (0.9)		3 (7.9)	16 (42.1)	13 (34.2)	6 (15.8)	38
Referrals received from **health professionals from MH** are in accordance with your organisation's policy for referral processes	2014	3.6 (0.8)	1 (3.1)	1 (3.1)	10 (31.3)	18 (56.3)	2 (6.3)	32
	2015	3.9 (0.9)		3 (7.7)	10 (25.6)	16 (41.0)	10 (25.6)	39
Health professionals from MH work collaboratively (with respect and recognition for each others' respective roles) with clinicians and other health professionals from your organisation?	2014	3.3 (0.8)		4 (12.5)	16 (50.0)	9 (28.1)	3 (9.4)	32
	2015	3.6 (0.9)	1 (2.6)	3 (7.9)	13 (34.2)	16 (42.1)	5 (13.2)	38
Health professionals from MH communicate care assessments or outcomes in a timely manner to all relevant healthcare practitioners involved in a client's care * *Sig Difference from 2014 to 2015*	2014	3.1* (0.7)	1 (3.2)	4 (12.9)	17 (54.8)	9 (29.0)		31
	2015	3.5* (0.9)		5 (13.2)	12 (31.6)	17 (44.7)	4 (10.5)	38
Health professionals from MH and health professionals in your organisation plan care jointly and deliver coordinated care where it is appropriate	2014	2.9 (0.9)	1 (3.2)	9 (29.0)	13 (41.9)	7 (22.6)	1 (3.2)	31
	2015	3.2 (1.1)	4 (10.5)	3 (7.9)	15 (39.5)	13 (34.2)	3 (7.9)	38

Working Relationships with cohealth (formerly Doutta Galla CHC)

In 2014, more than half of the respondents (61.7%) said they had had some professional contact with health professionals from Doutta Galla CHS in the past 6 months (Table 20Table 20). In 2015, just under half of the respondents said they had had some professional contact with cohealth (47%).

The response options for the five questions describing the frequency of a range of behaviours ranged from "never" (scored as 1) to "all of the time" (scored as 5). The distribution of responses is provided in Table 21, as is a mean and standard deviation for each item.

- The mean responses for the five questions about working relationships with health professionals from MCHS ranged from 3.4 to 3.7 (SD range 0.6-0.8) in both 2014 and 2015, indicating that most of the behaviours happened between "sometimes" and "often".
- IN 2015, the most frequently reported behaviour was in relation to working collaboratively (with respect and recognition for each others' respective roles), and the least frequently (but still more often than "sometimes") reported behaviour were around joint care planning and coordinated care delivery and communicating with all relevant health care professionals.

The small number of open-ended responses generally reflected positive experiences, including improvements.

- *Better feedback regarding referral outcomes. Still uncertain and not confident about the type/standard of diabetes management care provided.*
- *The relationship between MH and DGCHC (sic) has been very good. There has been streamlined referral pathways and timely access for patients referred to DGCHC. Communication between the two health services has been very good to improve patient care.*

Table 20: Proportion of respondents reporting relationships with health professionals from cohealth

	Time 1				**Time 2**			
DG1: Have you had professional contact with health professionals from Doutta Galla Community Health Centre (DGCHC)/coHealth over the past 6 months?	**Yes**		**No**		**Yes**		**No**	
	37	61.7	23	38.3	27	46.6	31	53.4

Missing = 29 T1 and 40 T2

Table 21: Feedback about working relationships with health professionals from DGCHC/cohealth

		Mean (SD)	**Never**	**Rarely**	**Sometimes**	**Often**	**All of the Time**	**Valid N**
Scoring of responses			(1)	(2)	(3)	(4)	(5)	
Communication (formal and informal) between **health professionals from DGCHC/cohealth** and health professionals in your organisation is timely and accurate	2014	3.7 (0.7)		1 (3.4)	10 (34.5)	16 (55.2)	2 (6.9)	29
	2015	3.5 (0.6)		1 (4.3)	9 (39.1)	13 (56.5)		23
Referrals received from **health professionals from DGCHC/cohealth** are in accordance with your organisation's policy for referral processes	2014	3.6 (0.6)			15 (51.7)	12 (41.4)	2 (6.9)	29
	2015	3.6 (0.6)			9 (40.9)	12 (54.5)	1 (4.5)	22
Health professionals from DGCHC/cohealth work collaboratively (with respect and recognition for each others' respective roles) with clinicians and other health professionals from your organisation?	2014	3.6 (0.8)		2 (7.1)	11 (39.3)	11 (39.3)	4 (14.3)	29
	2015	3.7 (0.6)		1 (4.3)	7 (30.4)	14 (60.9)	1 (4.3)	23
Health professionals from DGCHC/cohealth communicate care assessments or outcomes in a timely manner to ac involved in a client's care	2014	3.5 (0.6)			15 (53.6)	11 (39.3)	2 (7.1)	28
	2015	3.4 (0.8)		3 (13.0)	10 (43.5)	9 (39.1)	1 (4.3)	23

Health professionals from DGCHC/cohealth and health professionals in your organisation plan care jointly and deliver coordinated care where it is appropriate	2014	3.4 (0.8)		2 (7.4)	13 (48.1)	10 (37.0)	2 (7.4)	27
	2015	3.4 (0.8)		3 (13.0)	10 (43.5)	9 (39.1)	1 (4.3)	23

Summary across partner organisations

Comparison of the mean ratings (frequencies) for respondents commenting on working relationships with health professionals from each partner organisation reflected similar patterns in 2014 and 2015 (Table 22).

- In both years, planning care jointly and delivering coordinated care appeared as the least frequently practiced behaviour for health professionals from each partner organisation (rated on average as "sometimes", 2.9-3.6), followed by communicating care assessments or outcomes with other relevant health professionals in a timely manner (3.0-3.6).

Table 22: Mean (SD) ratings for inter-professional relationships with each partner organisation 2014

Time 1	**Doutta Galla CHC Mean (SD)**	**Merri CHS Mean (SD)**	**Melbourne Health Mean (SD)**	**GPs in the region Mean (SD)**
Number responding	27-29	25	31-32	52-53
Communication (formal and informal) between **health professionals from partner organisation** and health professionals in your organisation is timely and accurate	**3.7 (0.7)**	3.5 (0.7)	3.5 (0.7)	3.4 (0.7)
Referrals received from **health professionals from partner organisation** are in accordance with your organisation's policy for referral processes	3.6 (0.6)	3.4 (0.8)	**3.6 (0.8)**	**3.6 (0.6)**
Health professionals from partner organisation work collaboratively (with respect and recognition for each others' respective roles) with clinicians and other health professionals from your organisation?	3.6 (0.8)	**3.6 (1.0)**	3.3 (0.8)	3.2 (0.6)
Health professionals from partner organisation communicate care assessments or outcomes in a timely manner to all relevant healthcare practitioners involved in a client's care	3.5 (0.6)	3.4 (0.8)	3.1 (0.7)	3.0 (0.6)
Health professionals from partner organisation and health professionals in your organisation plan care jointly and deliver coordinated care where it is appropriate	3.4 (0.8)	3.3 (1.0)	2.9 (0.9)	3.0 (0.6)
Time 2	**cohealth CHC Mean (SD)**	**Merri CHS Mean (SD)**	**Melbourne Health Mean (SD)**	**GPs in the region Mean (SD)**
Number responding	N=22-23	N=38-39	N=25-26	N=57-60
Communication (formal and informal) between **health professionals from partner organisation** and health professionals in your organisation is timely and accurate	3.5 (0.6)	3.6 (0.9)	**3.8 (0.9)**	3.4 (0.8)
Referrals received from **health professionals from partner organisation** are in accordance with your organisation's policy for referral processes	3.6 (0.6)	**3.9 (0.9)**	3.6 (0.9)	**3.6 (0.8)**
Health professionals from partner organisation work collaboratively (with respect and recognition for each others' respective roles) with clinicians and other health professionals from your organisation?	**3.7 (0.6)**	3.6 (0.9)	**3.8 (0.9)**	3.3 (0.6)

Time 1	Doutta Galla CHC Mean (SD)	Merri CHS Mean (SD)	Melbourne Health Mean (SD)	GPs in the region Mean (SD)
Number responding	27-29	25	31-32	52-53
Health professionals from partner organisation communicate care assessments or outcomes in a timely manner to all relevant healthcare practitioners involved in a client's care	3.4 (0.8)	3.5 (0.9)	3.6 (0.9)	3.1 (0.7)
Health professionals from partner organisation and health professionals in your organisation plan care jointly and deliver coordinated care where it is appropriate	3 4 (0.8)	3.2 (1.1)	3.6 (0.9)	3.0 (0.8)

Mean ratings 3.5 and above in green cells (highest cells in darkest green); ratings below 3.5 in orange cells (lowest cells in darkest orange)

ABOUT THE LOCATION OF CARE

Questions about the extent to which care is perceived to be provided within the acute sector when it could be provided in the community were based on a similar set of questions asked in a survey of GPs by the combined hospitals in the region. There was no change in mean response from 2014 to 2015.

- Responses were similar in 2014 and 2015. Respondents indicated on average that care was "sometimes" provided in the specialist hospital outpatient clinics instead of the community, and there was a very wide distribution (Table 23).
- A similar proportion of respondents indicated that care was either "never or rarely" (12.2%) or "always or nearly always" (10%) provided in the acute setting. While the distribution was slightly less spread for the frequency with which care was provided in the acute setting instead of by local private GPs, the mean was similar.
- In both 2014 and 2015, there was only weak agreement with the statement that the location in which care is provided is appropriate to consumers' needs (4.4 in 2014, 4.2 in 2015; between agree slightly and moderately agree)(Table 24).
- The mean level of agreement with the statement about the extent of active efficient transfer between the acute and community-based care was lower again (3.9, agree slightly in 2014 and 3.6, mid-way between agree and disagree slightly in 2015) (Table 24).

These results support the importance of the work of the Collaborative, as they suggest that there is improvement to be made in the location of care appropriate to need within the local health system.

Table 23: Frequency of treating by MH over community health

		Mean (SD)	Never or rarely	Occasionally	Sometimes	Frequently	Always or nearly always	Don't know or NA
			1	2	3	4	5	
Provided ongoing care for patients from the INWM region in their specialist outpatient clinic that could have been provided by Community Health Centres?	2014	3.1 (1.1)	6 (12.2)	5 (10.2)	20 (40.8)	13 (26.5)	5 (10.2)	
	2015	3.2 (1.2)	6 (10.7)	8 (14.3)	18 (32.1)	15 (26.8)	9 (16.1)	26
Provided ongoing care for patients from the INWM region in their specialist outpatient clinic that could have been provided by local private GPs?	2014	3.2 (1.0)	3 (6.7)	7 (15.6)	18 (40)	14 (31.1)	3 (6.7)	
	2015	3.0 (1.1)	6 (11.8)	7 (13.7)	19 (37.3)	17 (33.3)	2 (3.9)	30

Table 24: Opinions about the way health care is delivered in the INWM region currently

		Mean (SD)	Strongly disagree	Moderately Disagree	Disagree Slightly	Agree slightly	Moderately Agree	Strongly agree	Don't know or NA
			1	2	3	4	5	6	
The location of the care that consumers in the INWM region receive (in the community and/or in the acute sector) is appropriate to their needs	2014	4.4 (1.1)		5 (8.2)	7 (11.5)	14 (23.0)	28 (45.9)	7 (11.5)	21
	2015	4.2 (1.2)		8 (11.4)	12 (17.1)	15 (21.4)	27 (38.6)	8 (11.4)	11
There is active efficient transfer of consumers between the acute and community (CHC and/or private GPs) in the INWM region	2014	3.9 (1.2)	1 (1.6)	9 (14.8)	13 (21.3)	15 (24.6)	21 (34.4)	2 (3.3)	21
	2015	3.6 (1.4)	4 (6.5)	13 (21.0)	11 (17.7)	12 (19.4)	18 (29.0)	4 (6.5)	17

In 2014, open-ended comments about where care is provided in the INWM region reflected concerns about the role of the acute sector providing care to consumers who could be managed in the community. There were some comments questioning the capacity of the community-based sector to provide appropriate care, confirming the need for ongoing workforce capacity building and increasing knowledge of skill levels.

In 2015, responses covered a number of themes, including:

- Where care should be located, with general support for the principle of more health care being provided in the community, although issues of capacity were raised. There were a couple of references to the impact of the INWMHC projects, and suggestions for targeting further work.
    - *Any client who does not need a hospital bed can see a GP or a Specialist in the Community Setting. There is absolutely no need for an out patients department in an acute setting; clients must have a more easily accessible service post hospital stay. Pre admission clinics are required only for those waiting for surgery*.
    - *I think more patients with Diabetes could be managed in General Practice; not sure about kidney disease and hopefully with the launch of the lower back pain health pathways, GPs will be more confident to manage patients rather than referring them to outpatients (surgical)*

- *Where hospitals pick up the slack and provide care that could be provided by GPs - often it's because the GP might have a lack of knowledge or confidence in managing the person's diabetes. We feel stuck between a rock and a hard place at times - you have to treat the patient because the GP obviously needs help in managing them. There is a pilot with the Diabetes demonstration projects that is working to upskill/raise confidence of GPs which is great - this is where I see the change needs to happen, I think we're reasonably good at trying to not to treat patients that we shouldn't be. I'm not saying all GP practice is poor, not at all, just that we feel a duty to help those that are struggling by helping manage their patients. The other issue is that diabetes is a chronic condition - many patients therefore will never be discharged. Also, you can set referral pathway guidelines, but there needs to be flexibility there.*
- *There is much work that the Collaborative should be doing to focus on influencing incentives that improve the integration of services to where the community would like to receive it, particularly in their role collectively with the state/fed governments.*
- *I think the Back Pain project has been successful in piloting transfer of clients from acute to community and using community as a better location for the provision of services. However this is a small pilot relative to the range of services provided via Melbourne Health. More redesign opportunities need to be rolled out.*

- Some specific suggestions were made, including:
  - *Please consider an/more edocrinology clinic at the CHS. This would improve where the health care is delivered, provide support for diabetes care in CHS, provide local endocrinology input to the GPs and enhance the role of the CHS in providing diabetes care. For consumers increasing the back pain clinic to direct referral in the CHS; capturing the clients even earlier in their journey to prevent hospital admission.*
  - *There should be a physiotherapy gym in Cohealth Kensington Site*
- Other facilitators/strategies noted included:
  - *Comprehensive support, engagement from the Department of Health and committed ongoing funding is required to support better localised specialist care for clients in INWM.*
  - *G.Ps often refer clients to MH for specialist care when those clients could have benefited from Allied Health. Often MH then refers to Allied Health since those clients aren't appropriate for specialist care. Hospital waitlists could be decreased by altering this approach.*

FEEDBACK ABOUT INWM HEALTH COLLABORATIVE

Respondents were asked a set of questions about the need for and value of the Collaborative. The mean responses were high, ranging between Moderately Agree to Strongly Agree (Table 25).

- The means were very stable from 2014 to 2015, indicating that there is still very strong support for the Collaborative.

The open-ended comments in 2014 suggested that it may be beneficial for the Collaborative to consider promoting the role it has in pursuing the objectives for system improvement more widely. This was identified as a potential area for action in the 2014 report. The Collaborative acted on this recommendation and undertook to develop a more strategic communication strategy.

In 2015, comments reflected support in general for the Collaborative as a mechanism for creating more integrated care. A number of themes emerged.

- **Increase awareness of the work within partner organisations for greater cultural change**
  - *Staff directly involved in the collaborative are very well aware of the details and strength of the collaborative. However I suspect staff not involved in the collaborative are not very well aware of the collaborative. Further education/communication about the collaborative to the general staff would be worthwhile.*
  - *The Collaborative has proved to be an extraordinary means to develop services across our region. From a management perspective the relationships built will mutually benefit each organisation well into the future. Further developing the relationships between clinicians at each organisation needs ongoing work.*
  - *Excellent and very valuable and effective initiatives. I'd like to see it continue. Great for networking and building confidence in the care that each other is providing - you know who you're referring to. In the end - this is great for our patients. Help with sharing the understanding of what the collaborative is about and the commitment to it - with other staff is a challenge, given my competing priorities and busy workload, I tend to be the one taking part in the collaborative but have trouble then spreading that further to the rest of my staff and the wider organisation (to the same degree that I am invested, I guess).*
  - *It would be great to see more personal interaction between clinicians between the CHCs and Hospitals particularly in the area of professional development. This would also be beneficial in gaining a better understanding of what other clinicians/hospital departments/CHCs do which may in turn improve the quality and appropriateness of the referrals in future.*
  - *Needs to be more communication on the work the collaborative is doing*
  - *The collaboratives are working mainly with management of my organisation and as a health care provider I feel that I am not given feedback about what is happening.*
- Recognising the challenges of sustaining the work of the Collaborative
  - *The work is adding value, however due to current funding models, the work is being done as an 'add on' to current workload. We need to design a sustainable and effective/efficient funding model to make this work mainstream and effective to the whole system.*
  - *Funding remains an issue - contributes to uncertainty about project futures and makes it impossible to offer a predictable, high quality service for referrers and their clients.*
  - *These relationship developments are in addition to our already oversubscribed service delivery, although potential to reduce what lists and times. Non-clinical time or session for information forums should be supported by our organisation.*
  - *Launched 3 years ago, and becoming larger with attendances at annual forum increasing, and projects increasing. Risks are that there is a lack of leadership, too many projects, not sufficient implementation/embedding/sustainability of projects, both in staff and consumer groups.*
  - *I think the Collaborative is ready to make the step with more projects and levels of collaboration. This may also involve developing some additional partners as the Primary Health network grows to cover a much larger area with more hospitals and Community Health Services. The Collaborative needs to be sustainable and adapt to a changing environment and not be reliant on enthusiastic staff at each organisation being prepared to be involved. It needs to be seen as core business in the acute sector (hospitals) as it is the only way of developing strategies to cope with increasing demand for services.*
  - *I think that the Collaborative needs: - a refresh of their intent. I feel like it has become a bit stale. The key projects have been the same for the last few years. Not to say that they should have new projects, but their communication and marketing of key achievements should be improved so that the updates we receive are not just 'we continue to work on it', as this loses*

the momentum - to clearly articulate its roadmap for transitioning to the PHNs. I think it is inappropriate and a waste of public funds to continue the Collaborative separate to the PHN effort. I have heard of limited activities to adopt different governance structures with the advent of the PHNs - to influence the PHNs on the development of a new framework and support / work with other Collaboratives within the PHN catchment - be more dynamic! It had good intent, but this has fallen off as perceived limited progress is made. It is starting to feel bureaucratic - to focus on developing programs that tackle identified problems, as opposed to be done because it is a 'good idea'. "For what purpose?" should be a key focus.

- There were a couple of respondents who queried the impact of working in formal partnerships or collaborations:
  - *Sometimes I believe it is only lip service but nothing is done practically and evaluation of these services with community health needs to be done by external auditors for unbiased evaluation*
  - *I don't think there is much evidence that these forms of collaboration produce much lasting benefit for any of the participants. Happy to be proven wrong, though.*

Table 25: Opinions about the Collaborative

		Mean (SD)	Strongly disagree	Moderately Disagree	Disagree Slightly	Agree slightly	Moderately Agree	Strongly agree	Don't know or NA
			1	2	3	4	5	6	
I believe there is a need for the Collaborative as a means of improving healthcare in our region	2014	5.6 (0.7)		1 (1.2)		3 (3.7)	22 (27.2)	55 (67.9)	4
	2015	5.7 (0.8)	1 (1.3)		1 (1.3)	2 (2.5)	11 (13.8)	65 (81.3)	3
There is a shared understanding of, and commitment to, the goals of the Collaborative among staff in my organisation	2014	4.6 (1.3)		5 (7.4)	8 (11.8)	19 (27.9)	15 (22.1)	21 (30.9)	16
	2015	4.8 (1.2)	1 (1.3)	3 (3.9)	7 (9.1)	18 (23.4)	22 (28.6)	26 (33.8)	6
The work is adding value (rather than duplicating effort) for the organisations involved in the Collaborative	2014	4.9 (1.2)	1 (1.4)	4 (5.8)	2 (2.9)	10 (14.5)	29 (42.0)	23 (33.3)	15
	2015	5.0 (1.0)		4 (5.7)	1 (1.4)	9 (12.9)	31 (44.3)	25 (35.7)	13
I believe the work of the Collaborative will contribute to better health outcomes for consumers in our region	2014	5.4 (0.8)		1 (1.4)	1 (1.4)	8 (10.8)	21 (28.4)	43 (58.1)	10
	2015	5.4 (1.0)	1 (1.3)	1 (1.3)	1 (1.3)	8 (10.3)	23 (29.5)	44 (56.4)	4

CLINICAL PATHWAYS

A set of questions asked respondents whether there were clear pathways for the key clinical areas being addressed by the Collaborative, whether respondents supported them, and whether they were implementing them. These questions reflect the core project areas of the Collaborative. The Diabetes Care project has been running the longest, followed by the Chronic Kidney Disease project. The Back Pain Clinical Pathways project

had recently begun when the 2014 survey was distributed and the ACP project had only just begun when the 2015 survey was distributed.

The expectation for these questions was that awareness of the clinical pathways would grow over time as a result of the work of the Collaborative.

Clinical Pathways for Diabetes Care

There were no significant differences in responses to the questions about clinical pathways for Diabetes care.

- Respondents agreed (moderately – 4.7/4.9) that there are clear clinical pathways for diabetes care and agreed more strongly (5.4, half way between moderately agree and strongly agree) that they support the recommended pathways (Table 26).
- Respondents agreed moderately (5.1/5.0) that they are implementing the recommended clinical pathways.

Table 26: Views about current clinical pathways for Diabetes Care

		Mean (SD)	Strongly disagree	Moderately Disagree	Disagree Slightly	Agree slightly	Moderately Agree	Strongly agree	Don't know or NA
			1	2	3	4	5	6	
There are clear clinical pathways for **Diabetes care**	2014	4.7 (1.1)		1 (2.3)	6 (13.6)	11 (25.0)	12 (27.3)	14 (31.8)	40
	2015	4.9 (1.3)	1 (2.3)	2 (4.7)	3 (7.0)	7 (16.3)	13 (30.2)	17 (39.5)	37
I support the recommended clinical pathways for **Diabetes care**	2014	5.4 (0.9)			1 (2.2)	9 (19.6)	9 (19.6)	27 (58.7)	38
	2015	5.4 (0.9)		1 (2.4)		7 (16.7)	9 (21.4)	25 (59.5)	38
I am implementing the recommended clinical pathways for **Diabetes care**	2014	5.1 (1.0)		1 (3.3)	1 (3.3)	4 (13.3)	11 (36.7)	13 (43.3)	53
	2015	5.0 (1.2)		2 (6.7)	2 (6.7)	4 (13.3)	8 (26.7)	14 (46.7)	49

Clinical Pathways for Kidney Disease Care

There were no significant differences in responses to the questions about clinical pathways for Kidney Disease care, although some means appeared to increase between 2014 and 2015.

- There was less strong agreement (just less than agree slightly – 3.8 – in 2014; 4.4 in 2015) that there are clear clinical pathways for kidney disease care than for Diabetes care, although respondents agreed moderately (5.2/5.3) that they support the recommended pathways (**Error! Reference source not found.**).
- Respondents only agreed slightly (4.2/4.4) that they were implementing the recommended clinical pathways.

Table 27: Views about current clinical pathways for Kidney Disease Care

		Mean (SD)	Strongly disagree	Moderately Disagree	Disagree Slightly	Agree slightly	Moderately Agree	Strongly agree	Don't know or NA
			1	2	3	4	5	6	
There are clear clinical pathways for **Kidney disease care**	2014	3.8 (1.3)		5 (20)	4 (16)	9 (36)	4 (16)	3 (12	56
	2015	4.4 (1.4)		5 (13.9)	5 (13.9)	6 (16.7)	11 (30.6)	9 (25.0)	44
I support the recommended clinical pathways for **Kidney disease care**	2014	5.2 (0.9)				6 (31.6)	3 (15.8)	10 (52.6)	61
	2015	5.3 (0.9)		1 (2.8)		6 (16.7)	11 (30.6)	18 (50.0)	42
I am implementing the recommended clinical pathways for **Kidney disease care**	2014	4.2 (1.5)	1 (7.7)	1 (7.7)	1 (7.7)	5 (38.5)	2 (15.4)	3 (23.1)	68
	2015	4.4 (1.6)	2 (9.1)	1 (4.5)	1 (4.5)	7 (31.8)	4 (18.2)	7 (31.8)	57

Clinical Pathways for Back Pain Care

The was a strong and significant **increase** in the mean level of agreement to the statement that there are clear clinical pathways for back pain care from 2014 to 2015, rising from mid-way between disagree slightly and agree slightly, to midway between agree slightly and agree moderately. This is a positive indication of the effect of the project.

- In 2014, there was no agreement (mid-way between disagree slightly and agree slightly – 3.5) that there were clear clinical pathways for back pain care. This rose to 4.6 (mid-way between agree slightly and agree moderately) in 2015
- Respondents agreed moderately at both time points (5.1/5.3) that they support the recommended pathways (Table 28).
- Respondents only agreed slightly to moderately (4.4 in 2014; 4.7 in 2015) that they were implementing the recommended clinical pathways.

Table 28: Views about current clinical pathways for Back Pain Care

		Mean (SD)	Strongly disagree	Moderately Disagree	Disagree Slightly	Agree slightly	Moderately Agree	Strongly agree	Don't know or NA
			1	2	3	4	5	6	
There are clear clinical pathways for **Back Pain care** ***Sig Difference from 2014 to 2015, p=0.001*	2014	3.5** (1.5)	3 (10)	7 (23.3)	3 (10)	8 (26.7)	7 (23.3)	2 (6.7)	52
	2015	4.6** (1.4)	2 (4.1)	3 (6.1)	4 (8.2)	10 (20.4)	15 (30.6)	15 (30.6)	31
I support the recommended clinical pathways for **Back Pain care**	2014	5.1 (1.2)		2 (7.7)		4 (15.4)	8 (30.8)	12 (46.2)	56
	2015	5.3 (1.0)	1 (2.4)			7 (16.7)	11 (26.2)	23 (54.8)	36

		Mean (SD)	Strongly disagree	Moderately Disagree	Disagree Slightly	Agree slightly	Moderately Agree	Strongly agree	Don't know or NA
			1	2	3	4	5	6	
I am implementing the recommended clinical pathways for **Back Pain care**	2014	4.4 (1.3)		2 (14.3)	2 (14.3)	1 (7.1)	7 (50.0)	2 (14.3)	68
	2015	4.7 (1.4)	2 (6.9)		3 (10.3)	4 (13.8)	10 (34.5)	10 (34.8)	50

Clinical Pathways for Advance Care Planning

The Advance Care Planning project was just commencing at the time of the survey.

- Respondents agreed slightly that there were clear clinical pathways for ACP.
- Respondents agreed moderately at both time points (5.1) that they supported the recommended pathways (Table 28).
- Respondents only agreed slightly (3.8) that they were implementing the recommended clinical pathways.

Table 29: Views about current clinical pathways for Advance Care Planning

		Mean (SD)	Strongly disagree	Moderately Disagree	Disagree Slightly	Agree slightly	Moderately Agree	Strongly agree	Don't know or NA
			1	2	3	4	5	6	
There are clear clinical pathways for Advanced Care Planning	2015	4.0 (1.6)	4 (10.8)	3 (8.1)	6 (16.2)	7 (18.9)	10 (27.0)	7 (18.9)	43
I support the recommended clinical pathways for Advanced Care Planning	2015	5.1 (1.4)	1 (3.1)	2 (6.3)		6 (18.8)	3 (9.4)	20 (62.5)	48
I am implementing the recommended clinical pathways for Advanced Care Planning	2015	3.8 (1.9)	4 (16.7)	4 (16.7)	2 (8.3)	4 (16.7)	2 (8.3)	8 (33.3)	55

CONCLUSION

All of the means for the strength of collaboration questions at both times indicated that the majority of respondents thought the governance group in which they were involved had positive characteristics and demonstrated positive attitudes and behaviours. That is, in 2015, respondents continued to **strongly endorse** the view that the governance group with which they were involved **had positive characteristics and demonstrated positive attitudes and behaviours.**

While all of the characteristics of collaboration that were assessed using the Thomson et al. measure scored highly, comparison of the means of each of the subscale total scores from 2014 to 2015 indicated that the ratings of "mutuality" had increased significantly from 2014 to 2015 (21.8 to 25.6, $p<0.001$). The mean overall total score was also significantly higher in 2015 compared with 2014 (77.8 compared with 72.7, $p<0.02$). These

characteristics all contribute to effective functioning of the governance groups and the Collaborative as a whole.

- Analysis of the sub-scale scores confirmed that there was NO significant difference between the mean scores of respondents from different governance groups in 2014 or 2015. This indicates that participants in the different governance groups considered that the group with which they were involved is displaying positive characteristics in relation to domains of governance, administration, autonomy, mutuality and Norms/Trust..
- Similarly, comparison of mean scores when respondents were grouped according to the sector they represent (Community Health, Acute, General Practice) indicated no significant differences on any of the sub-scales in 2014 or 2015. This indicates that the perspectives of respondents was not associated with the sector they represented.

The data indicated very high levels of consistency of behaviour and attitudes with the foundational principles of the INWMHC by respondents' own organisations (means 5.0-5.7 in 2014 & 5.1-5.6 in 2015).

- Comparison of mean scores when respondents were grouped according to the sector they represented (Community Health, Acute, General Practice) indicated no differences in respondents' views about the extent to which their own organisation or partner organisations were demonstrating the foundational principles in 2014 or 2015.
- There were no differences comparing views for respondents from different governance groups in 2014 or 2015.
- There was no significant differences in the responses to the questions from 2014 to 2015, indicating that respondents continued to believe that their own and partner organisations were demonstrating attitudes and behaviours consistent with the INWMHC's foundational principles.

While all means were high, in 2014 it was suggested that the Collaborative should monitor and discuss the potential conflict between meeting and balancing the needs and expectations of the collaborative at the same time as those of each individual organisation. This was based on the observation of a significant difference between respondents from the medicare local and others (ML respondents were more positive than others, although all were moderately positive). The Mutuality questions relate to the extent to which respondents perceive organisations are sharing information and resources, achieving goals through the partnership, and working through any differences. This difference was not observed in 2015; in fact, the ratings of "mutuality" increased significantly from 2014 to 2015. This is a very positive sign and suggests the Collaborative has successfully addressed any issues underlying the earlier results.

Familiarity with INWHMCH

Awareness of the specific activities of the INWMHC was greatest in relation to the Diabetes Project and the Chronic Kidney Disease project in 2014, reflecting that these were the two earliest projects undertaken by the Collaborative. In 2015, a greater proportion of respondents was aware of the different projects, ranging from 45% for the ICT project to 82% for the Back Pain Project.

In 2014, most survey respondents (62%) said they had not been directly involved with activities undertaken by the Collaborative (Table 13). Those who had been involved described being involved in working parties and projects, as well as attending the Annual Collaborative Forum. In 2015, a greater proportion of the survey respondents reported they had been directly involved in activities undertaken by the Collaborative (53%), with most people indicating they were involved in a number of activities.

Summary across partner organisations

Comparison of the mean ratings (frequencies) for respondents commenting on working relationships with health professionals from each partner organisation reflected similar patterns in 2014 and 2015. In both years, planning care jointly and delivering coordinated care appeared as the least frequently practiced behaviour for health professionals from each partner organisation (rated on average as "sometimes", 2.9-3.6), followed by communicating care assessments or outcomes with other relevant health professionals in a timely manner (3.0-3.6).

Location of care

The survey results support the importance of the work of the Collaborative, as they suggest that there is ongoing improvement to be made in the location of care appropriate to need within the local health system.

- In both 2014 and 2015, there was only weak agreement with the statement that the location in which care is provided is appropriate to consumers' needs (4.4 in 2014, 4.2 in 2015; between agree slightly and moderately agree).
- The mean level of agreement with the statement about the extent of active efficient transfer between the acute and community-based care was lower again (3.9, agree slightly in 2014 and 3.6, mid-way between agree and disagree slightly in 2015).

Need for the Collaborative

Means from questions about the need for and value of the Collaborative were stable from 2014 to 2015 indicating that there is still very strong support for the Collaborative.

- "The work is adding value (rather than duplicating effort) for the organisations involved in the Collaborative." 89.8% agreed (75.3% moderately or strongly) in 2014 compared with 92.9% (80% moderately or strongly) in 2015
- "I believe the work of the Collaborative will contribute to better health outcomes for consumers in our region." 97.3% agreed (86.5% moderately or strongly) in 2014 compared with 96.2% (85.9% moderately or strongly) in 2015

References

Australian Commission on Safety and Quality in Health Care (2012). *Practice-level indicators of safety and quality for primary health care specification*, ACSQHC, Sydney.

Thomson, A.M., Perry, J.L., & Miller, T.K., (2007). Conceptualizing and Measuring Collaboration. *Journal of Public Administration Research and Theory,* Advance Access 2007.

Lewis, V., Jordan, L., Redfern, J., & Bakacs, L. (2005). *An evaluation of the Primary Care Partnership Strategy, October 2005*. Prepared for the Department of Human Services, Victoria. **www.health.vic.gov.au/pcps/downloads/eval_pcp_strat.pdf**

Lewis, V., Marsh, G., Macmillan, J., White, V., Silburn, K. (2011). *Connecting Healthcare in Communities (CHIC) State-wide Evaluation Final Report, December 2011.* Report prepared for Queensland Health (QH).

Appendix A: Inner North West Melbourne Health Collaborative Framework

COLLABORATIVE FRAMEWORK

Foundation collaboration principles:

- Patient and client centred – we will seek to understand and incorporate how patients and clients experience the health system through our collaboration.
- Commitment and participation – we are committed to the partnership and will actively participate in the collaboration.
- Positive working relationship – we will ensure fair and transparent decision making, recognising the strengths, culture and voice of all partners and build on the achievements of each department.
- Complementarity – we will build on the distinctive contribution of all partners, and ensure that our combined efforts bring about change.
- Transparency – we will share information and ideas that will support and strengthen collaborative projects, programs and processes.
- Independence – we will value and respect independence within the partnership, recognising contributions and acknowledging each others' strengths.
- Outcome focused – we will focus on the end goal rather than the process.
- Equal standing and responsibility – All partnering organisations have an equal standing in the partnership and we are equally responsible for the outcomes of the partnership and the health of our community.
- Joint learning – we will learn from each other, with the aim of incorporating learning, communications and knowledge-sharing into the relationship.

Appendix B: Key Stakeholder semi-structured interview questions

Chief Executive Committee Members (individually)

1. What is the main thing your organisation wants to achieve by being member of the collaborative?

2. Do you think all members are equally committed to the collaborative?
   a) Is there a high level of trust within the collaborative?

3. Do members clearly understand :
   b) What resources member organisations are contributing (including finances and in-kind support)?
   c) Their responsibilities and accountability as member organisations for performance of collaborative?

4. Is the energy/time/effort you and your organisation put into the collaborative commensurate with the benefits generated for your organisation?
   a) Do you think the benefits of participation are equal for all members?

5. Would you be meeting with the individual members of the collaborative if the collaborative didn't exist?
   If yes:
   a) For what reasons would you meet?
   b) What benefits are being derived or would you expect to derive from collaborative participation, that you would not otherwise achieve through bilateral partnerships?

6. What do you think are the key achievements of the collaborative to date?

7. What needs to be done to continue to progress the collaborative?
   a) Are there any barriers/ issues to this being achieved? If so, how might they be overcome?

Senior Managers' Steering Committee Members (individually)

1. What is the main thing your organisation wants to achieve by being member of the collaborative?

2. Do you think all members are equally committed to the collaborative?
   a) Is there a high level of trust within the collaborative?

3. Do members clearly understand :
   a) What resources member organisations are contributing (including finances and in-kind support)?
   b) Their responsibilities and accountability as member organisations for performance of collaborative?

4. Is the energy/time/effort you and your organisation puts into the collaborative commensurate with the benefits generated for your organisation?
   a) What have been the costs to your organisation financially (directly and indirectly) to be a member of the collaborative? (in the past and ongoing)

b) Do you think the benefits of being part of the collaborative are equal across collaborative members?

5. Would you be meeting with individual members of the collaborative if the collaborative didn't exist? If yes
   a) For what reasons would you meet?
   b) What benefits are being derived or would you expect to derive from collaborative participation that you would not otherwise achieve through bilateral partnerships?

6. How well do you think the collaborative is addressing its five strategic priorities?
   a) Redesign services to improve coordination, interface and client experiences
      - Yes/No If yes, how?

   b) Respond to the highest healthcare needs in our catchment
      - Yes/No If yes, how?

   c) Drive a collaborative culture across our workforce
      - Yes/No If yes, how?

   d) Embrace ehealth to improve systems connections
      - Yes/No If yes, how?

   e) Demonstrate collaborative results
      - Yes/No If yes, how?

7. Do you think your organisation is changing as a result of being a collaborative member? If so, how?

8. Do you think other organisations are changing as a result of being a collaborative member? If so, how?

9. Is the current governance structure for the collaborative—CEs committee, Senior Managers Steering committee and Project committees—the optimal governance structure to achieve the goals of the collaborative? If not what changes would you suggest?

10. Does the Senior Managers' Steering Committee operate in a manner consistent with the collaboration principles articulated for the INWMHC?

    a) E.g., fair and transparent decision making; recognise strengths, culture and voice of all partners; share information and ideas to support and strengthen; value and respect independence; have an equal standing and be equally responsible for outcomes; learn from each other.

11. What needs to be done to continue to progress the collaborative? Are there any barriers/ issues to this being achieved? If so, how might they be overcome?

Collaborative project steering groups (As groups)

1. What is the CKD project hoping to achieve?
   [If not already covered, COULD ask: Do you think this project fits well into the overall objectives of the Collaborative?]

2. Will the potential benefits of your project's success be experienced equally across collaborative members?

3. Overall, do you think the project has been resourced and supported well by the Collaborative partner organisations to date?

[May lead to a discussion about differences in commitment, contribution, support, etc. Could ask specifically "Has everyone has contributed similarly?" if the opportunity arises – without being critical.]

4. What are the benefits of having all members of the collaborative involved in the project (as opposed to just two or three partners working together)?

5. Now that you're ready to implement plans arising from the project to date, how could the Health Collaborative help you to support the project and overcome any potential barriers or issues that arise?

Other Stakeholders (individually)

1. What has been your contact or involvement with the Collaborative to date?
   a) Has the Collaborative changed the way you interact with the other member organisations?

2. What is the main thing your organisation wants to achieve by being a member of the collaborative?
   b) Do you think the potential benefits of participation are the same for all organisations?

3. Do you think all members (the organisations) are equally committed to the collaborative?
   a) Do you think there is commitment within your organisation – across different areas, levels, etc?

4. What do you think are the key achievements of the collaborative to date?

5. How are the collaborative arrangements helpful in shifting provision of health care?
   a) Does it shift care to the right places?

6. What needs to be done to continue to progress the collaborative?
   b) Are there any barriers/ issues/ risks to this being achieved? If so, how might they be overcome?

Victorian Department of Health Regional Office

1. What do you see as the purpose of the Collaborative? (From the point of the partners first, and then perhaps from his perspective.)

2. What is it trying to do that other arrangements—such as MOUs, partnerships, agreements—haven't done in the past?

3. Do you think all members (the organisations) are equally committed to the collaborative?

4. What do you think are the key achievements of the collaborative to date?

5. (if not already raised) How are the collaborative arrangements helpful in shifting provision of health care?

6. Does it shift care to the right places?

7. What needs to be done to continue to progress the collaborative?

8. Are there any barriers/ issues/ risks to this being achieved? If so, how might they be overcome?