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## Building collaborative practice with consumers in rural and remote Australia

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### Introduction

A contemporary Australian health system must be characterised by partnerships with consumers. Partnering with consumers is about healthcare organisations, healthcare providers and policy makers actively working with consumers to ensure that health policy, information, systems and services meet their needs. Recognition of the need for a more active role for consumers in healthcare is gaining momentum. However, there is limited systemic focus on building the capacity and expertise of consumers to serve as leaders, agents of change and service improvers despite this being recognised in the literature as an important, co-creation role consumers can play. Experience of innovative approaches to system improvement and service development that build on people's lived experience of health and healthcare can transform services. Patients or consumers need to be seen by providers and managers as an asset to planning, priority setting and decision making.

The King's Fund, (an independent charity in the UK) have developed a program **Collaborative Pairs** which is designed to support the development of the mindset and practices that underpin the culture of shared leadership and partnership and, specifically, joint clinician-consumer approaches to program and service development. According to Alison Trimble, 'Consumers are renewable energy and the secret ingredient to transformational change within the health and care system'.<sup>1</sup> Collaborative practice underpins co-design and is essential to implementing current health reforms in Australia.

Given this context, Consumers Health Forum of Australia (CHF) in partnership with four Primary Health Networks (PHNs) and the Australian Commission on Safety and Quality in Health Care (ASQHC) is undertaking a national demonstration trial of the King's Fund **Collaborative Pairs** program to test the effectiveness of this innovative program for the Australian context as a mechanism for building capacity for collaborative leadership that can drive system change. One of the PHNs investing in this National Demonstration Trial is Western NSW PHN which covers one of the most significant rural and remote regions in Australia

This paper will provide an overview of the Collaborative Pairs Program, the model being implemented in the National Demonstration Trial with a specific focus on Western NSW. The challenges and opportunities of delivering a world class innovative program in a remote location will

be discussed as well as the need to build capacity of both consumer and clinical leaders to work together in rural and remote Australia.

## Role of consumers in a contemporary health system

Australia has made significant inroads to systematically and strategically incorporate consumers interests into policy and practice. These span many sectors and industries. The developments we have witnessed since the mid-1980s include the following:

- There is clear and growing value placed on consumer insights, advice and lived experience in policy making, program and service development.
- Demand for consumer representatives on national, state and regional committees and in policy roundtables and forums is strong: it is rare to see high level national committees without a consumer member.
- The case for consumer participation in governance and advisory arrangements is encouraged at all levels. Examples can be seen in organisations such as LHD's and PHN's.
- The adoption of frameworks such as the International Association for Public Participation's Spectrum of Engagement or variations of it is also commonplace and this has encouraged a more systemic and strategic approach to consumer participation
- National Safety and Quality Health Service Standards now exist for Australian health care organisations (HCOs) against which all are accredited. These include standards pertaining to patients as partners in care, a standard which commenced as a developmental standard, but which is now compulsory
- CHF and the National Health and Medical Research Council (NHMRC) have a Joint Statement on *Consumer and Community Involvement in Health and Medical Research*<sup>2</sup>, updated in 2016, to promote and support consumer and community involvement across all types and levels of health and medical research

However, despite these developments, co-design, co-production and co-creation are emergent concepts with the associated practice only just starting to enter health lexicon. There is a plethora of principles and terms that convey the intent that health care is primarily about people. Terms such as 'consumer centred care', 'consumer engagement', 'participatory health', 'consumer participation', 'co-design' and 'partnering with consumers' are ever present in national, state and local health policies and plans although variable in the degree they are practised. A chasm between policy intent and these principles being put into practice remains a great risk. There are programs and service models emerging that give effect to these policies of greater control and choice for consumers such as the National Disability Insurance Scheme (NDIS), aged care reforms and patient-centred health care homes.

## Collaborative practice and health reform

Changes in the healthcare system in the developed world over the last decade are moving to having consumers and the broader community at the core of the health system. Enabling consumers and communities to gain greater control over, and contribute to better health outcomes, involves reorienting or reengineering the system to focus on the enablers (ie health literacy, access to shared information, shared decision making) and the settings in which this will take place.

As highlighted earlier, in the last few decades, there has been greater recognition of the need for a more active role for consumers in health care, what is often referred to as consumer choices and consumer voices aiming to improve service delivery, consumer experience and health outcomes. However, there is a considerable way to go with regard to how to best harness the role of consumers as agents of change in a systems and service development sense.

In the current context, the *role of consumer leaders needs to be reconceptualised* to include improving health and wellbeing in the community and /or improving health and social care services. This is achieved through consumers working with others to influence decision-making. CHF, in its recent White Paper ‘Shifting Gears: Consumers Transforming Health’<sup>3</sup> articulated a range of roles for consumers in transforming health in the future and the acknowledgement that the consumer role is not one dimensional.

Underpinning these roles is the need to build consumer capability and capacity to partner with health care providers, policy makers and researchers in influencing and shaping the system of health care. In 2013 The King’s Fund began exploring the concept of consumer leadership with a view to understanding how they could support its growth and development within the health system. It became apparent that consumer leadership requires a whole-of-system approach which goes beyond a deficit-based approach of simply building the capacity of consumers and citizens as leaders to one that supports ***culture change and a new relational paradigm*** for consumers and health care professionals. The underlying principle is that ***consumers, managers and service providers are all equal in an effective health system.***

## The ‘Collaborative Pairs’ program

***Collaborative Pairs*** is a leadership training program that supports the development of the mindset and practices that underpin the culture of shared leadership and partnership and, specifically, joint clinician-consumer approaches to program and service development in health and improvement in regional and service delivery settings. This unique program is designed to assist clinicians, managers, patients and consumers to learn together to build productive relationships and to appreciate and practice how different roles and perspectives can be a constructive force for change. The program’s objectives are to build skills in developing collaborative partnerships and to break down the cultural barriers that often exist between those providing the services and those receiving them.

This program has been designed for pairs from the same local health area or region to work together on a shared challenge. One half of the pair will be a patient or consumer leader and the other half of the pair will be a clinician or health service provider who wants to find new ways of working with consumers. The program is undertaken over five days usually one day every four to six weeks to allow the pairs to work on a shared work challenge in between sessions. The *Collaborative Pairs* program is predominantly experiential, designed to expose participants to a range of different methodologies and tools that contribute to developing effective collaborative practice. These include Action Learning, Peer Consulting, Appreciative Inquiry, Open Space and World Café. These tools are helpful for holding critical conversations, communicating different perspectives, developing dialogic communication and influencing.

The evidence base on which the program has been developed is well summarised in the King’s Fund 2014 publication ‘***People in control of their own health and care***’.<sup>4</sup> The paper makes a clear distinction between the critical role for consumers being involved in their own care—self leadership—and the role of consumers working with other leaders (e.g. clinical, managerial, community) to engage in leadership tasks such as visioning, governance, strategic planning, decision

making and service redesign. Whilst these two roles share some of the same capabilities, there are also some different implications for how health organisations will need to work with consumers and citizens to fulfil these different roles. The evidence clearly indicates that when consumers are involved, decisions are better, health and health outcomes improve, and resources are allocated more efficiently.

Achieving a more collaborative dynamic will require a change in the way that all of us work. The ability to adapt, communicate and shift between roles will be important for all leaders in developing the collaborative relationship that puts safety and quality at the heart of health care in our communities. (Alison Trimble, The King's Fund<sup>5</sup>)

## The national demonstration trial in Australia

The national demonstration trial aims to bring this cutting-edge program to Australia for the first time. The point of difference between this program and other programs currently available in Australia is that it brings consumers and health service providers together to address the relational issues in working collaboratively. The National Demonstration Trial in Australia involves a collaboration between CHF, the King's Fund (UK), and four participating PHNs from NSW and Victoria: Western NSW, Western Sydney, NorthWestern Melbourne and South Eastern Melbourne. It is a two-year project which commenced in July 2017.

Funding was also made available by the ACSQHC to undertake an external evaluation of the National Demonstration Trial. This current investment in Collaborative Pairs Australia has led to:

- the establishment of a Project Steering Group
- project administration, governance and management by CHF for 2 years
- training of 4 Facilitator pairs in the UK
- implementation of 2 programs in each of the PHN sites including supervision by the King's Fund.

The model for implementation in each of the PHNs has included a collaborative planning process between CHF, the facilitators delivering the program and the PHN. This has involved familiarising the PHN with the program, determining who the program will target, how the program will build capability for collaborative practice, promotion of the program and process for selection of pairs.

The Australian facilitators have committed to the delivery of two programs in each of the participating PHNs for the duration of the demonstration, sourcing participants through collaboration with PHNs. This will mean up to 8 pairs will participate in each program, and up to 8 programs will be conducted. The pairs participating in the trial will form a Community of Practice.

The diversity of geographical areas of the participating PHNs will enable the model to be tested across urban, regional and remote contexts. Having Western NSW PHN involved in the National Demonstration Trial has meant that the model can be tested in a rural and remote region of Australia.

## Importance of collaborative practice in a rural and remote location

The Western New South Wales Primary Health Network (WNSW PHN) region covers both Western NSW and Far West Local Health Districts across an area of 433,379 square kilometres. The population is estimated to be over 309,000 people (ABS 2016), living in regional centres and small

rural and remote townships. Approximately 10.5% of people in the region identify as Aboriginal and Torres Strait Islander.

The largest seven population centres are Bathurst, Orange, Dubbo, Broken Hill, Parkes, Mudgee and Cowra—with a combined population of approximately 53% of the regional population. There are over 50 other small towns and communities spread across the region with populations less than 10,000 people. More than a third of the regions Local Government Areas are classified amongst the most disadvantaged nationally. Western NSW's involvement in the Collaborative Pairs Program is driven from a need to adopt new approaches to designing health service solutions through collaborations between health consumers and clinicians in rural and remote settings, across a very large and diverse geographical footprint.

Community and consumer engagement (CCE) is now recognised as a critical component in delivery of care to individuals but also in the planning, delivery and evaluation of health care at the system, community, practice and individual level.<sup>6</sup> Effective engagement with consumers and communities requires organisations to use multiple approaches, in order to create opportunities for different groups to participate and to achieve the intended outcomes of the engagement.<sup>7</sup>

Rural and remote communities experience additional challenges related to large geographic areas and dispersed populations, and the associated issue of representation. Multilevel approaches to CCE in rural communities are needed to maintain a local sense of place while applying policy, resourcing and supporting at a regional level.<sup>8</sup>

WNSW PHN has adopted a Consumer and Community Framework to provide a structure to guide and support development of effective consumer and community engagement.<sup>9</sup> WNSW PHN's approach to engagement addresses the challenges of working in rural and remote settings, and to acknowledge the uniqueness of every town and community. In the context of the WNSW PHN region, engagement is 'the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people'.<sup>10</sup>

Collaborative Pairs in Western NSW provides a systemic approach to collaboratively address health challenges and opportunities based on the context in which the PHN operates. The benefits it will provide include bringing consumers and clinicians together in the communities in which they live and work, and those who are remote from each other. This is a reflection of how rural health operates and where people, who may have connections and common interests, are often separated by many 100's of kilometres. In these situations, people travel long distances to meet together and now use audio and video technology to connect more regularly.

## Early learnings from implementing the Collaborative Pairs program in Western NSW

There have been many learnings on every level in planning and implementing this program in Western NSW PHN. The learnings so far will be distilled at three levels:

- planning and take-up of the program
- recruitment process
- delivery of the program.

### Planning and take-up of the program

One of the initial barriers to the program was the lack of understanding that the PHN had about the program, the use of metropolitan based facilitators and the relevance of the program. This required a great deal of work from both the facilitators and CHF in helping PHN staff understand the concept of the program, its relevance and the need for the program. The facilitators invested time in building a collaborative relationship with their partner (the PHN) in the planning process for the delivery of the program. As well as spending a half hour in weekly teleconferences, the facilitators also committed to attending cultural awareness training, meeting face to face with potential applicants and participating in Community Council meetings. This modelling of partnership development at the highest level was critical to developing a program that would meet the needs of the region as well as building trust and confidence in the facilitators.

The ongoing vision of the CEO to introduce new ways of working and investing in this program was a contributing factor to interest and take up of the program.

### Recruitment process

Initially, one of the challenges was the role of 'PHNs' as commissioning agents and that this program required 'pairs' to apply, not individuals. This meant that the PHN didn't always have the direct relationship with consumers and communities and not all service providers, mainly those they were commissioning and therefore didn't have the networks immediately accessible to promote the program to. After the initial failed attempt in recruiting, largely through internal networks, the PHN went more broadly and promoted the program through wider networks utilising partners and existing relationships. This proved to be much more successful in attracting pairs to the program.

Another challenge was that in a remote and regional population (smaller numbers), attracting people to a program that will essentially be a 'disruptor' is challenging. It requires risk takers, leaders and gamechangers that become the early adopters. This is a more limited target group in a region with a smaller, disparate population. This required identifying some key people in the region that had these attributes and encouraging them to apply. The first cohort undertaking the program would become the champions of 'change'.

A further challenge was that roles are often blurred in a rural and remote location. People can be consumer/carer and health professional all at the same time so gaining clarity on the perspectives and pairings was important. This led to the need for greater clarification of the perspectives of the pairs and what constituted a 'pair'.

The initial locations targeted for the program were Dubbo and Broken Hill (Far West) but it became evident that the interest and energy was predominantly with the Dubbo and Bathurst areas of the region. However, there remained strong interest from a couple of pairs in Broken Hill.

### Delivery of the program

The challenges of distance, different time zones, interest, budget and relevance all had to be factored in to the program design as well as other more unique issues such as not driving at dusk due to the risk of 'hitting kangaroos'. Due to the skill, flexibility and responsiveness of the facilitators to the needs of the region, a bespoke program was developed which included pairs from Broken Hill participating in the Dubbo program through a multi-modal approach (ie video-conferencing, facetime and face to face). A second program is being delivered in Bathurst and given the two programs are being run on consecutive days, the final session will be a joint session with both programs.

The two programs have only recently commenced and as the sessions are 4 to 6 weeks apart, it's too early to discuss impacts of the program other than to say that co-designing the program content between the participants and facilitators has been a critical factor in ensuring the unique characteristics of working and living in a remote location are addressed.

## Conclusion

In summary, the King's Fund Collaborative Pairs program is currently being trialled in Australia to test its potential to develop consumer and clinical leaders that can effect change through new ways of working together. Western NSW, one of the sites for the trial being co-ordinated by CHF in partnership with the King's Fund, 4 PHNs and ACSQHC demonstrates that 'collaborative practice' involves collaboration at all levels. It also highlights the factors that define rural and remote practice such as distance, time zones, less role delineation, less workers, less services and pragmatism that need to be considered in designing and delivering a program that builds collaborative practice. In general, rural and remote practice cannot be successful without collaboration and so defining what collaborative practice really means in terms of transforming the health system in a rural and remote context is a useful starting point. Early learnings would suggest that this will look quite different to an urban context where roles are more clearly delineated and there are often more layers to service provision. Rural and remote practice is more intuitively linked to breaking down cultural barriers and working across sectors and settings and therefore well positioned to use the Collaborative Pairs program to build capability to drive service integration and system reform.

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## Presenters

**Leanne Wells** is the Chief Executive Officer of the Consumers Health Forum of Australia. She is a health advocate and service executive with over thirty years' experience in health and social policy, program and service development. Leanne has held executive positions within federal government and in national and state non-government organisations. Leanne is Board Director of Coordinare South East New South Wales' Primary Health Network, the Ozhelp Foundation, PainAustralia and the Australian Pharmacy Council. She is the Independent Chair of Coordinare's Community Advisory Committee. She has several advisory appointments, including the Commonwealth's Primary Health Care Advisory Group, NSW Agency for Clinical Innovation's International Expert Advisory Committee and the Primary Care Committee of the Australian Commission for Safety and Quality in Healthcare's Board. Leanne has tertiary qualifications in communications and business. She is a member of both the Australian Institute of Company Directors and the Australian Institute of Management.

**Andrew Harvey** is the CEO of the Western Health Alliance Limited, which operates the Western NSW Primary Health Network ([www.wnswphn.org.au](http://www.wnswphn.org.au)). He was previously CEO of the Darling Downs South West Queensland Medicare Local Limited. Andrew has held economic and community development management roles in local government in Australia and New Zealand. Andrew has a Bachelor of Agricultural Science from the University of Canterbury in New Zealand, is a Graduate of the Australian Institute of Company Directors and has a Graduate Certificate in Management from the AIM Business School. Andrew is the non-executive Director of Westhaven Ltd, a Dubbo-based Disability.