

An independent evaluation of the Collaborative Pairs Australia National Demonstration Trial



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Final Evaluation Report

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Collaborative Pairs Review

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1. Executive Summary

The Consumers Health Forum of Australia (CHF) engaged the University of New South Wales, Canberra and Curtin University to conduct an independent evaluation of the Collaborative Pairs Australia National Demonstration Trial. The purpose of the evaluation is to assess the effectiveness and applicability of the program in the Australian context and inform future implementation of the program.

In 2015 the King's Fund ran a series of Collaborative Pairs programs in England, a leadership development initiative that brings together a consumer, patient or community leader to work together in pairs with a service provider, clinician or manager to develop new ways of working together. The program aims to develop partnerships and to break down the cultural barriers that often exist between those providing services and those receiving them.

The trial involves a collaboration between CHF, the King's Fund (UK), and four PHNs from NSW and Victoria: South Eastern Melbourne, North Western Melbourne, WentWest and Western NSW. Initial planning for the trial began in July 2017 followed by CHF recruiting 4 pairs of facilitators.

The principal features of the Collaborative Pairs program in Australia are:

- Facilitation by a consumer lead and one clinician/manager lead in each pair who receive supervision from Kings Fund mentor
- Participants are clinicians and consumers paired together to form a joint clinician-consumer partnership
- Program is delivered over five one-day face-to-face sessions with three to six weeks in between sessions
- Program includes theoretical and experiential learning in relation to communication, conflict resolution, partnerships and collaborative working
- Pairs identify and work on a project during the program as a vehicle for exploring their collaborative working relationship

The specific objectives of the evaluation are to

- a) Provide an assessment of the program's relevance, receptiveness and acceptability in the Australian context;
- b) Assess the program's effectiveness in building collaborative relationships that will impact on practice and lead to system changes in the way health services are designed, developed and implemented;
- c) Inform any further implementation of the program (i.e. a sustainable business and delivery model); and,
- d) Build the evidence base on collaborative practice, leadership and transformational change.

The evaluation explores the characteristics of the program, the setting, the characteristics of individuals involved in implementation and processes used in implementing the trial through interviews with participants, facilitators and key stakeholders and document review.

44 pairs of participants commenced the 7 programs, with 31 pairs completing. The evaluation finds the Collaborative Pairs program is relevant and acceptable in the Australian context. The program demonstrates a positive impact on some participants in terms of new skills, thinking and approaches to communication, collaboration and partnership. The impact on sponsoring organisations was less evident due to low numbers of participants from each organisation and the time that may be required for cultural change to develop. A number of recommendations are made regarding the marketing, recruitment, format and evaluation of the program to inform future iterations:

Marketing and recruitment

1. Clarify program objectives, highlight experiential aspect of program and articulate anticipated benefits to participants and sponsoring organisations in marketing
2. Clarify time commitment to all program activities
3. Recruitment exclusion criteria to include pairs in current therapeutic relationship
4. Redefine role of project in program as a vehicle to explore collaborative work
5. Co brand with sponsoring organisation where possible
6. As part of recruitment assess commitment of sponsoring organisations providing participants
7. Use experienced facilitators as part of recruitment to model and explain program objectives
8. Provide forum for facilitators to meet applicants prior to confirmation of selection

Facilitation

9. Contextualize facilitators resources to Australian context
10. Develop facilitator peer support network
11. Remunerate facilitators according to time spent on additional administrative tasks and travel time

Program format

12. Introduce clear program and session objectives
13. Consider guest speakers to model desired outcome
14. Reduce interval between session to maximum 3 weeks
15. Reduce length of day for participants
16. Allow greater time for discussion through reducing didactic content
17. Provide between session participant coaching by facilitators
18. Investigate session recording/other mechanism for participants who miss sessions
19. Investigate mechanism for post program community of practice or peer support network

Evaluation

20. Record session attendance, participant background (clinician/manager, consumer, consumer leader) and project type and progress, and reason for drop out
21. Introduce pre and post measure of attitudes to collaborative working
22. Involve facilitators and key stakeholders (e.g. sponsoring organisations, CHF) in future design of evaluation
23. Evaluate the impact of programs located within direct provider organisations in future iterations of the program.

2. Acknowledgements

The UNSW evaluation team would like to thank the participants, facilitators and organisational representatives for their time and enthusiastic participation in the interviews that formed the basis of this evaluation. We are also grateful for the feedback received from interviewees on an earlier version of this report. Finally, we would like to thank the staff at CHF for their assistance provided to us in undertaking this evaluation.

3. Acronyms and Definitions

Acronyms

ACSQHC	Australian Commission for Safety and Quality in Healthcare
CHF	Consumers Health Forum of Australia
CFIR	Consolidated Framework for Implementation Research
PHNs	Primary Health Networks
SEMPHN	South Eastern Melbourne Primary Health Network
NWMPHN	North Western Melbourne Primary Health Network
WNSWPHN	Western NSW Primary Health Network
WSydPHN	WentWest Primary Health Network

Definitions

Sponsoring organisation

Refers to the organisation that program participants are affiliated with (e.g. health service or mental health service). PHNs are referred to by name in this report, except where PHN staff were participants in the program and PHNs are then referred to as sponsoring organisations

Consumer

Members of the public who use, or are potential users of health and/or community-based services

Consumer leader

Someone who voices consumer perspectives and takes part in the decision-making process on behalf of consumers

Patient

A person receiving medical services. Note this term is used in this report only where used in original source material

Collaboration

Two or more individuals and/or organisations working together to create or achieve the same goal/outcome.

4. Introduction

The Consumers Health Forum of Australia (CHF) in collaboration with the King's Fund (UK) and four Primary Health Networks (PHNs) in New South Wales and Victoria have undertaken an Australian national demonstration trial of the King's Fund Collaborative Pairs program that brings together a consumer, patient or community leader to work together in a pair with a service provider, clinician or manager to develop new ways of working together. The program aims to develop partnerships and to break down the cultural barriers that often exist between those providing services and those receiving them.

An independent evaluation of the Collaborative Pairs Australia National Demonstration Trial (the trial) was funded by the Australian Commission for Safety and Quality in Healthcare (ACSQHC). The University of New South Wales, Canberra and Curtin University were appointed by the Consumer Health Forum of Australia (CHF) to undertake the evaluation. The aim of the evaluation is to assess the effectiveness and applicability of the program in the Australian context and inform future implementations of this program.

This document outlines the evaluation of the trial. It first describes the context, aims and features of the trial. The evaluation approach, questions and methods are then outlined. This is followed by a description of the key findings of the evaluation and recommendations for future program implementation.

The independent evaluation finds the Collaborative Pairs program is applicable to the Australian context. The trial changed the way some participants understand the nature of consumer and provider relationships and how collaborative working relationships could be developed. The impact of the program on sponsoring organisations is less evident as numbers of participants from each organisation were limited and the time required for cultural change to develop is typically longer than this trial was able to allow for. Several key recommendations addressing program recruitment, facilitation and format are made to inform future iterations of the program.

4.1. Collaborative Pairs context

In recent years, a number of countries, including Australia, have aimed to reorientate their health systems from being provider-driven, to ones that place the consumer and community at the forefront of the health care system. Evidence suggests where patients are actively involved in their own care, we see improved health outcomes and overall efficiency gains (Coulter, Roberts, and Dixon 2013, Hibbard and Greene 2013). Although in many developed health systems there is political will and demand from the public to put the patient at the centre of their care, actually making the shift to a patient centred system has proved to be a challenge (Foot et al. 2014, Gold, Hossain, and Mangum 2015, Weissman, Millenson, and Haring 2017). A recent King's Fund review of patient involvement in health care (Foot et al. 2014) suggests slow progress is largely due to the difficulty of the cultural and behavioural changes posed by a shift of this nature. This is not just about changing a few organisational practices, but instead breaking down vested interests and long-established ways of thinking and doing. This does not just require policy change, but for patients and health professionals to think and act in different ways (Foot et al. 2014, Weissman, Millenson, and Haring 2017, Gold, Hossain, and Mangum 2015).

If Australia is to move to a more consumer-focused system, it is imperative the capacity of both consumers and health professionals is improved and there is cultural change to deliver more effective collaboration between these groups. Collaborative Pairs was developed by the King's Fund and is a program that aims to do precisely this through enabling and supporting 'cultural change and a new relational paradigm for consumers and health care professionals' (Consumers Health Forum of Australia 2017b).

In 2015, the King's Fund ran a series of Collaborative Pairs programs in England. While no formal evaluation of the King's Fund program has been undertaken, a summary of learnings indicates the potential benefits of investing time to enable collaborative learning and relationships to develop and embed this activity within existing organisational systems. In lieu of formal evidence around the quantifiable benefits and impact of the Collaborative Pairs program, the broader literature provides some insight into the anticipated benefits of a program such as this. A growing body of evidence indicates involving patients across the spectrum of health care, from the individual level of self-care to the collective level of the broader health system, has a number of benefits (Ocloo and Matthews 2016, Gardner, Dickinson, and Moon 2019).

Benefits of consumer participation in the health sector include increased efficiencies in health services, improved health outcomes, increased patient choice, improved patient experience, increased trust in the health care team, reduced health care costs to the patient and system, increased value and use of medical research, and increased patient satisfaction and compliance with treatment (Australian Commission on Safety and Quality in Health Care 2011, Janamian, Crossland, and Wells 2016, Ocloo and Matthews 2016, Scholz, Bocking, and Happell 2017). Involving consumers in the delivery of clinical tertiary health care can reduce hospital costs, costs per patient, and length of hospital stay (Sweeney, Halpert, and Waranoff 2007, Australian Commission on Safety and Quality in Health Care 2017). A literature review exploring the effect of community participation involving individuals and organisations working together to inform health service planning, decision-making, and program implementation reported improved health outcomes, service access, utilisation, quality and responsiveness, with recommendations that policy makers should strengthen policy and funding mechanisms to support consumer participation in primary health care (Bath and Wakerman 2015). Overall, active consumer participation can lead to more accessible and effective health services (Consumer Focus Collaboration 2001).

4.2. Objectives of Collaborative Pairs

The Collaborative pairs program is a leadership training program that supports the development of practices that underpin a culture of shared leadership and collaboration (Consumers Health Forum of Australia 2017a) and improvement in regional and service delivery settings (Consumers Health Forum of Australia 2017b). The program aims to provide an opportunity for 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 powerful catalyst to enable change. The objectives are to build skills in developing partnerships, and to break down the cultural barriers that often exist between those providing the services and those receiving them. The underlying principle of the program is based on the assumption that consumers, managers and service providers are all equal in an effective health system.

4.3. Features of the Collaborative Pairs Australia National Demonstration Trial

The trial involves a collaboration between CHF, the King's Fund (UK), and four PHNs from NSW and Victoria: South Eastern Melbourne (SEMPHN), North Western Melbourne (NWMPHN), WentWest (WsydPHN) and Western NSW (WNSWPHN). PHN involvement in the trial stemmed from early discussion initiated by SEMPHN with CHF about potential programs to foster consumer leadership. Part of PHNs' mandate relates to consumer engagement and some were looking for projects that go beyond the 'usual approaches'. Once CHF identified the collaborative pairs program other PHNs were approached regarding their involvement in the trial. Key stages of the trial are presented in Figure 1.



Project planning commenced in July 2017. The King's Fund partnered with CHF and the PHNs to develop and implement a facilitator training program for four pairs of facilitators, including one consumer lead and one clinical/manager lead in each pair. Governance occurred through a steering group comprised of CHF and PHN staff that met periodically throughout the trial.

Facilitator pairs were recruited by CHF through an expression of interest process. The pairs underwent a five-day training program in the UK in March 2018 to equip them to deliver the program in Australia. Australian facilitators were engaged to deliver two programs in each of the participating PHNs covering a range of urban, regional and remote contexts. The CHF expression of interest document articulated the primary responsibility of facilitators for delivery of the program, while PHNs and CHF were primarily responsible for recruiting participants, registrations, provision of venue and other administrative issues related to the delivery of the program. The King's Fund provided support and coaching to facilitators for the duration of the demonstration by way of skype meetings, webinars and email support. Facilitators were paid a flat fee for their time delivering the program, which covered approximately 8 days per program (5 days delivery, half day supervision, one and half day's preparation and follow up).

The intention was for program participants to be clinicians and consumers paired together to form a joint clinician-consumer partnership. Participants were invited to apply for participation in the program by their PHN as a consumers and health service 'pair'. Table 1 provides details of the facilitators and program dates.

TABLE 1: FACILITATORS AND PROGRAM DATES

PHN	FACILITATORS	PROGRAM	PROGRAM START DATE	PROGRAM COMPLETION DATE
SEMPHN	Russell McGowan Dr. Paresh Dawda	SEMPHNG1	October 2018	April 2019
		SEMPHNG2	February 2019	June 2019
NWMPHN	Louisa Walsh Dr. Chi Li	NWMPHNG1	October 2018	February 2019
		NWMPHNG2	February 2019	June 2019
WNSWPHN	Jane Cockburn Karen Patterson	WNSWPHNG1	February 2019 (Dubbo & Broken Hill)	July 2019
		WNSWPHNG2	February 2019 (Bathurst)	July 2019
WSydPHN	Debra Kay Dr. Wally Jammal	WSydPHNG1	February 2019	August 2019
		WSydPHNG2	(Scheduled for 2020)	(Scheduled for 2020)

The program was delivered over five one-day face-to-face sessions with typically three to six weeks in between sessions. Participants from Broken Hill joined by video link due to the remoteness of their location. Facilitators held an in-person meeting with Broken Hill participants prior to the commencement of the program.

The content of the program was intended to cover the following topics:

- Developing relationships across the health system with people who might have different perspectives and priorities
- Developing the tools and practices to handle difficult conversations
- Developing the tools and techniques to effectively communicate across the health system
- Understanding the power dynamic in collaborative practice and how to shift it to become more equal
- Effectively managing the political context
- Understanding personal leadership and conflict resolution styles
- Building a support network to develop partnerships in the workplace

Part of the program involved the pair working on a quality improvement project they had identified. The project was used as a vehicle for the development and reflection on their collaborative working relationship.

The program focus is on relationships and the factors that contribute to effective collaborative practice through experiential learning, reflection and analysis. Local variation in the delivery of the program was evident, reflecting the flexible approach to the use of a vast array of resources and tools the facilitators were provided with during training. All sessions ended with a form of knowledge capture exercise that involved a participant session review. Participants had access to additional resources via an online portal, basecamp.

5. Evaluation approach

This section outlines the evaluation objectives and the approach taken to the evaluation. The evaluation design, data collection and analysis methods are described.

5.1. Evaluation objectives

The evaluation of trial aims to provide practical recommendations and evidence that will inform any future implementation of the program. The specific objectives of the evaluation are to:

- a. Provide an assessment of the program's relevance, receptiveness and acceptability in the Australian context;
- b. Assess the program's effectiveness in building collaborative relationships that will impact on practice and lead to system changes in the way health services are designed, developed and implemented;
- c. Inform any further implementation of the program (i.e. a sustainable business and delivery model); and,
- d. Build the evidence base on collaborative practice, leadership and transformational change.

5.2. Evaluation approach

The evaluation involves a two-stage process. In stage 1, a review of existing knowledge and work in this area was undertaken, especially in relation to work by the King's Fund (see, Spark, Robinson, and Dickinson 2019). Stage 2 involved an evaluation of the trial and is the focus of this document.

The trial evaluation design drew on established methodologies suitable for a program early in its development and implementation phases. Such methodologies are able to:

- take into account the broader context (i.e. health system individuals, institutions and organisations, and the impact this could have on the program and the evaluation results).
- incorporate a participative evaluation approach that allows the voice and perspective of relevant stakeholders (including the consumer) to be heard; and
- Provide results of practical relevance for the funder (CHF), participants and the broader health system

The evaluation is based on the Consolidated Framework for Implementation Research (CFIR), a conceptual framework developed to guide systematic assessment of complex interventions and programs (Damschroder et al. 2009). It comprises a menu of constructs arranged within five domains, namely:

- characteristics of the program;
- the inner setting (implementing organisation);
- outer setting (external context or environment);
- characteristics of individuals involved in implementation;
- And, the process used in implementing the intervention.

Qualitative methods were used to explore these five domains as described in the next section. Ethical approval for the evaluation was obtained through UNSW human ethics committee (HREC number HC180329).

5.3. Data collection and analysis

Data were collected via semi structured interviews and a review of key documentation. Semi structured interviews were conducted with the following groups:

- Participants involved: Health professionals and consumers post program completion
- Inner setting: Facilitators during and post program implementation, PHN staff during implementation
- Outer system: ConsumersHealthForum during implementation and King's Fund post-program implementation

Interviews were conducted with 40 people in total. The number of interviewees in each group are shown in Table 2

TABLE 2: STAKEHOLDER INTERVIEWS

INTERVIEWEE TYPE	NO. OF INTERVIEWS DURING PROGRAM IMPLEMENTATION	NO. OF INTERVIEWS POST PROGRAM IMPLEMENTATION
CHF	1	-
Kings fund	-	1
PHN	10	-
Facilitators	6	8 <small>(*NSW facilitators interviewed prior to last session)</small>
Participants	-	14
TOTAL	17	23

A UNSW participant information statement and consent form was sent to all program participants by CHF and the UNSW evaluation team, from contact information provided by PHNs. Consents were received from 29 providers/clinicians and 13 consumers. The evaluation aimed to interview one consumer and one clinician/provider in each program cohort. However, no consumer participants provided consents from SEMPHNG1 and WNSWPHNG1 after two email follow ups by the evaluation team. Table 3 shows the breakdown of participant interviews by program and pair type.

TABLE 3: PARTICIPANT INTERVIEW PROFILE

PHN	NO. OF CLINICIANS/ PROVIDERS INTERVIEWED	NO. OF CONSUMERS INTERVIEWED	TOTAL NO. OF INTERVIEWS
SEMPHN G1	2	0	2
SEMPHN G2	0	2	2
NWMPHN G1	1	1	2
NWMPHN G2	1	0	1
WSydPHN G1	1	1	2
WNSWPHN G1	3	0	3
WNSWPHN G2	1	1	2
TOTAL	9	5	14

Semi structured interviews explored key themes including; motivation for involvement in the program, what worked well, what worked less well and key lessons arising from the demonstration trial. Interviews were audio-recorded and key themes and quotes from each interview were documented in a proforma and these were shared across researchers. All interview documents were analysed for key themes against the main evaluation questions. A desktop review of program documentation included participation data, knowledge capture data and project descriptions. This data was analysed to calculate program demographics, project types and learnings.

6. Evaluation Findings

Findings from analysis of interviews and documentation are outlined in this section. Reflections on the process of recruitment, training and supervision of facilitators are first described and then characteristics of the pair participants are examined. This is followed by an examination of the program format and content. Finally, the impact and implications for the future are addressed.

Findings are presented in relation to key themes raised by participants in interviews. For reasons of confidentiality, given the small sample size, comments are not always identified as being from PHN project managers, facilitators or the participant cohort. However, where possible while maintaining anonymity differences in these perspectives are indicated.

6.1. Recruitment, training and supervision of facilitators

Facilitators were recruited and selected by CHF through an expression of interest process. Facilitators' interest in participating in this project stemmed from their belief in the importance of consumer engagement and wanting to see this become more embedded within their systems locally.

We now have the toolkit and the desire to make a difference (facilitator)

We really wanted to make change and weren't scared to make change (facilitator)

Those with a consumer engagement background reported having championed this cause for some time and saw the Collaborative Pairs program as a way to positively contribute to further developing this agenda. Some clinician facilitators have a consumer engagement background, while others were persuaded by being individually approached by those they respect and/or because the model seemed compelling.

Some facilitators report being attracted to the program because in addition to driving consumer engagement in an innovative approach, they saw this as a good way to develop their facilitation skills. However, beyond a broad sense the program would drive consumer engagement and improve health outcomes, both PHNs and facilitators alike reported lacking a sense of how the program worked or would work precisely. There was some confusion initially between what the quality improvement projects should achieve and how this related to the overall program aim of culture change and rebalancing power relations.

The group of facilitators travelled to London for a week of training with the King's Fund. Facilitators reported enjoying the training and finding it insightful.

[the King's Fund] took us through an experience on steroids... and improved my self-awareness

A few facilitators noted they would have benefited from greater depth of understanding of some key concepts in the program. For some, it was their first exposure to collaborative relationship theory:

Even for some of the other who were very experienced it was clear that there were some new things there

A facilitator with minimal facilitation experience initially felt 'ill equipped' and 'struggled with the language'. The initial training was a significant financial commitment for the program and some facilitators suggested it was incredibly useful to be immersed in the learning with the group overseas, but that it might be possible to do this more cheaply within country as skills around the program are developed in Australia. However, some were keen to point out that in order for this to be effective there would need to be individuals with a deep level of knowledge and experience in consumer/clinician relationships and the program, highlighting that the knowledge and skills of those based at the King's Fund were judged to be substantial.

While facilitator confidence in delivering the program generally increased by the second cohort, the supervision provided by the King's Fund was seen as 'absolutely crucial' (facilitator) in deepening understanding, particularly in relation to the dynamics of collaboration. Facilitator supervision was based on a 'model of the very process' (King's Fund) that program participants experienced. Facilitators commented on the value of supervision in enabling them to design activities and manage individual participants, as well as reflecting on their behavior with participants and their co-facilitator. How collaboration was modelled to participants by the facilitator pair or 'how they showed up' (King's Fund) was a particular focus of supervision. The value of supervision was reflected in comments by facilitators that this would also be beneficial in the program development phase.

Facilitators identified the need for supports in addition to programmed supervision. A mechanism for ad hoc 'employee assistance' as needed for facilitators was seen as important in a program involving intense relationship dynamics. Facilitators also felt a lack of formal structure for peer debriefing. In its absence, facilitators created informal opportunities to share learnings and experience with other facilitators. Facilitators brought different skills, strengths and experience to the program and interpreted the program in different ways. Opportunities for facilitator networking and reflection were seen as a way for facilitators to assist each other with problem solving. CHF was seen as having a key role in organising a forum for facilitator networking in future iterations of the program.

The period between facilitator training and first cohort program implementation was longer than had been initially intended – between 7 and 11 months. From a facilitator perspective this interval presented a challenge in terms of confidence and familiarity with program material. Facilitators needed to spend time refamiliarising themselves with the material prior to program delivery.

Summary: Facilitator training and supervision

WHAT WORKED WELL

- **King's Fund Training**
- **Formal Supervision**

WHAT COULD BE IMPROVED

- **Development of peer support network for facilitators (and consideration of employee assistance)**
- **Reduce interval between facilitator training and program delivery**

6.2. Participant demographics

Table 4 presents an overview of the number of pairs commencing and completing within each of the seven programs conducted within the evaluation timeframe. Program completion is defined as participant pairs completing most or all sessions and demonstrating engagement throughout the duration of the program. Project completion was not a necessary requirement for program completion. The project was one mechanism through which the program aim of building a collaborative working relationship was developed. In most cases collaborative work on projects continued beyond the program delivery. As this table demonstrates, all of the PHNs experienced some attrition of pairs and within one group (SEMPHN Group 1) no pair completed the program.

TABLE 4: PROGRAM PAIR COMMENCEMENT AND COMPLETION

PHN	GROUPS	NO. OF PAIRS COMMENCED	NO. OF PAIRS COMPLETED	COMMENTS
SEMPHN	Group 1	6	0	See 6.3 for comment on participant composition
	Group 2	8	6	
NWMPHN	Group 1	8	6	One pair completed one session only One pair completed 1st 4 sessions
	Group 2	7	6	8 pairs enrolled and one withdrew before commencement. One pair left program after 2 sessions
WNSWPHN	Group 1	5	4	
	Group 2	5	5	
WSydPHN	Group 1	5	4	
TOTAL		44	31	

Overall there was a 70% completion rate. If SEMPHN group 1, where no pair completed, is excluded from the calculations as an outlier the completion rate is 82%.

Recruitment aimed at ensuring a patient or consumer leader was paired with a clinician or health service provider. At the WNSW PHN groups fewer patient/consumer leaders were recruited resulting in four pairs consisting of PHN and provider representatives or provider and provider representatives. Data is available for 84 of the 88 participants who commenced the program. Table 5 outlines the composition of consumers and clinicians/providers in each group.

TABLE 5: PAIR COMPOSITION

PHN	GROUPS	NO. OF CONSUMERS	NO. OF CLINICIANS OR PROVIDERS
SEMPHN	Group 1	6	6
	Group 2	8	8
NWMPHN	Group 1	7	7
	Group 2	6	6
WNSWPHN	Group 1	3	7
	Group 2	3	7
WSydPHN	Group 1	5	5
TOTAL		38	46

The organisational type the 46 clinician or provider pair participants originate from are presented in Table 6. This demonstrates some spread, but greatest numbers of participants across community-based organisations and hospitals.

TABLE 6: CLINICIAN/PROVIDER SPONSORING ORGANISATION TYPE

PROVIDER/CLINICIAN ORGANISATION TYPE	NUMBER OF PARTICIPANTS
Community based organisation	17
Acute Hospital	13
PHN	8
Private practice	4
Government or tertiary education	4
TOTAL	46

6.3 Pair recruitment process

The pair recruitment process was originally envisaged as a shared CHF and PHN responsibility. CHF held a familiarisation session with PHN staff and facilitators and took them through a planning process in May 2018. Rather than centrally determined processes and procedures for recruiting pairs, this was left to the local level so they would be developed in a way appropriate to context. PHN staff worked with facilitators to plan the process and timeframe for their two programs. CHF provided an expression of interest form that could be customised for each PHN to assist recruitment and also placed FAQs and promotional material, including a video, on the CHF website. Some of this supporting material was not available for programs that commenced in 2018.

Interested pairs were required to provide a brief written application addressing their motivation for undertaking the program, current understanding of collaborative practice, pair history, ideas for a project and expectations for the program impact on their pair and sponsoring organisation. Applicants were also required to state their availability and commitment to attend all five sessions.

As a consequence of locally determined procedures, PHNs took different approaches to recruitment. Some used their existing consumer engagement structures, while others did not. Some PHNs developed their own marketing material and pushed this through their own networks. Some facilitators felt they could have had more involvement in the development of material to ensure an appropriate pitch and language. Facilitators felt the marketing of the program needed greater emphasis on the relational building process within the program. Suggestions for marketing the program included presenting it as a '5-day experiential learning program', a collaborative leadership experience or a process of relational development. The key to marketing was seen to be in highlighting an experience of a process and not promising a concrete set of deliverables. The challenge for the future is in clearly articulating the benefits of the experiential approach to sponsoring organisations.

Some PHNs felt they were left with too much to determine locally and some greater codification by CHF would have been helpful. PHNs reported they needed to commit additional resources to the program in terms of recruitment, but also other facets that we discuss below. Facilitators also reported recruitment had taken more of their time than expected.

Challenges in recruiting were largely summarized as relating to a steep learning curve and a lack of sufficient guidance. This was cited as particularly important as some reported struggling with the messaging of the program.

People [participants] felt like it was what they already did. 'I already engage with consumers, I already work with clinicians, I'm on a consumer advisory committee, I don't understand why this is different'. [it was] hard to describe a process when people are used to outcomes. Started to talk about it in terms of leadership development

PHNs found the program difficult to explain at the outset and there was a perceived lack of clarity in the outcomes it was aiming to achieve beyond some broad aspirations. PHNs reported the program was easier to explain to consumers than to some clinicians as for the latter group it is perceived as representing a very different way of working for some.

From the PHN perspective, the benefits of being a sponsoring organisation included raising awareness of consumer leadership within the organisation and the ability to provide a neutral space for participants to attend. There was a suggestion that a lack of familiarity with the PHN brand could be overcome by co-branding with local provider organisations. In contrast, some stakeholders questioned the fit of the program with PHNs and their ability to recruit effectively. As relatively new commissioning organisations within their localities, some perceive PHNs as insufficiently close to health care providers. The benefits of a sponsoring organisation being a direct service provider was presented in terms of the potential to ensure organisational commitment and a greater number of staff from an organisation attending to 'get the momentum for culture change and construct an ongoing community of practice'.

Some individuals placed outside PHNs experienced challenges working with these organisations. They were described by some as being quite bureaucratic institutions that were sometimes difficult to navigate due to many layers of decision-making. This was further compounded by the high degree of turnover in terms of the contact team at PHNs.

Table 4 indicates the number of pairs recruited in different cohorts was between 5- 8 pairs. CHF recommended 8 pairs per program should be a maximum number. However, some facilitators felt 8 pairs was too many and the program may be more effective with fewer pairs. Many of the programs struggled to recruit their first wave of pairs. Most found the process of recruitment easier in the second cohort of programs with clearer marketing of the program and sponsoring organisations already prepared for engagement after the first cohort. Recruitment generally required a two to three-month lead-in time. Regional areas reported greater recruitment challenges and this was reflected in fewer pairs in WNSW cohorts (see Table 5). Several of the pairs in these two programs were PHN staff paired with provider participants. A participant explains their decision not to participate in the first cohort was related to the need to find a consumer pair, a requirement that was relaxed in the second cohort:

We did try and engage a consumer...[Facilitators] encouraged us to get a consumer..., well how do we sell that to them, how do we get 5 days of their time, how do we pay for that, how do we get them to come and talk about their health journey. We didn't know how to do that. (Provider participant WNSWPHNG)

The NSWPHN facilitators felt there was value in broadening the understanding of participants from a strict clinician/consumer dichotomy to include those who are closely involved with community or those who had multiple roles. Building relationships between participants from 'diverse perspectives' was seen as the key objective. However, these facilitators also encouraged provider pairs to find consumer involvement where possible.

Facilitators identified the need to assess organisational support as a key consideration in future recruitment processes. Strong sponsoring organisation engagement with, and understanding of, the program was important in the organisation assisting with recruitment, enabling staff participants to attend all sessions and translating learnings into the organisation. One facilitator described this,

We talked about the three-legged stool, the pair in the room is only two legs of the three-legged stool, the missing leg or the absent leg is the sponsoring organisation. Some of them weren't really that supportive

The variable commitment evident from sponsoring organisations had an impact on participant experience of the program and the support they received. At the King's Fund, initial contact with the sponsoring organisation is considered crucial. Facilitators with experience delivering the program are involved at this initial stage to model and explain the relational elements. This is seen as helping organisations to understand this as a process, rather than a traditional course and to clarify the organisation's objectives in participating in the program.

A mix of reasons for participation in the program were described by pairs including:

- Interest in further developing skills in this area
- Opportunity to network with wide range of stakeholders
- Opportunity to work with medical professionals/consumers
- Opportunity to progress planned project
- Request from manager to participate – several participants indicated their managers were looking to increase numbers at request of PHN
- Request from pair partner to join program

Clinician/provider participants were sponsored by their organisation for time spent at the program. However, it was recognised that consumers may be forfeiting potential earning time through their attendance. Some areas addressed this perceived difference through remunerating consumer participants for attending and picking up some expenses such as childcare.

Pair and facilitator characteristics

While facilitators were involved in planning the recruitment process, as described above, most PHNs and facilitators reported the need for greater facilitator involvement in ensuring the suitability of pairs identified through the recruitment process. Facilitators felt the opportunity to meet potential participants, even virtually, would be useful in identifying the characteristics of pairs more likely to benefit from and to complete the program. Characteristics considered important included being motivated, open to new experiences and engaging in less familiar and less structured experiential elements of the collaborative relationship building processes. Those participants who were more task and project focused were often perceived to be less willing to engage in the relationship building process.

Completion rates presented in Table 4 indicate most programs experienced drop out of 1-2 pairs. Reasons given for drop out, where provided, included one of the pair experiencing:

- change in employment
- difficulty with childcare (consumer)
- ongoing consumer health/welfare issues
- clinician/provider illness

No pairs in the SEMPHN1 program completed. These participants were exclusively from mental health and/or alcohol and other drug services. While this background was seen as a positive in terms of their non-traditional insights on health and welfare, this presented challenges for consumer participation in the program. Concerns were expressed about stresses placed on participants either through clinicians struggling to support consumers or consumers struggling to understand the program and manage the commitment.

We had a woman who was really, really enthusiastic but because of her medication couldn't turn up until a certain time and then had to leave early because her concentration...she just couldn't manage the full day (PHN)

Many consumer participants in this cohort were currently receiving services. Facilitators and clinician participants interviewed described the additional stress on consumers who were in the midst of dealing with active issues in therapeutic work as being a barrier to completion. In addition, several consumers were in current therapeutic relationships with their clinician pair. This brought an existing power imbalance/way of relating between consumer and clinicians to the program that facilitators and participants reported as being unhelpful in changing the relationship dynamics through the work of the program.

A couple of participants in other programs commented on the challenges of changing relationship dynamics when they had a long pre-existing relationship with their pair.

I got a lot out of the cross collaboration with the other people there I didn't know, and it raised the question for me 'should we be paired with strangers?' (Provider participant)

When participants fully engaged, the program was described as being;

Very transformational ... and can open up a lot of opportunities. Participants who have really engaged have seen the broader application of this program to consumer engagement and can become strong advocates. (Facilitator)

Most participants and facilitators strongly felt that a face-to-face component of recruitment involving facilitators, was essential in assisting participants in understanding the objectives, format and commitment required of the program. SEMPHN did trial a virtual meeting via zoom with applicants and facilitators in their first program and found it worked poorly partly due to applicants' incorrect use of the virtual platform.

Summary: Pair Recruitment

WHAT WORKED WELL

- **Majority of pairs collaborated well together**
- **Greater facilitator involvement in pair recruitment**

WHAT COULD BE IMPROVED

- **Centralised messaging and marketing of program objectives, benefits and format by CHF to sponsoring organisations and participants**
- **Facilitator involvement in selecting pairs from applicants, potentially through a face-to-face component**
- **Clarifying program commitment including between session interactions (particular consideration for consumer managing recent or acute health/mental health issues)**
- **Prevent recruitment of pairs in current or recent therapeutic relationships**
- **Assess sponsoring organisation engagement as part of recruitment. This could involve an organisational readiness checklist to determine level of support**
- **Consider maximum number of pairs for new facilitators**
- **Co-brand with sponsor organisations where possible**

6.4. Reflections on the program

Interviewees were asked what worked well in the program and what could be improved. This section presents their perspectives on the program format, content and knowledge capture mechanisms.

Format

When asked about the program, most participants remarked on the format and delivery of the program, rather than program content. Participants commented on the session length and spacing.

The content was really good but it could be cut back, didn't need to be so drawn out (SEMPHNG1 Provider Participant)

Participants had several suggestions around changes to program timing and format that included:

- Shortening days and reducing program content to reduce time and concentration burden on some consumers who found the program too demanding
- Reducing interval between sessions
- Plan program schedule to avoid long summer break
- Consideration of physical environment of facilitation to improve participant comfort (e.g. seating)

Participants had variable understanding of the role of the project in the program and this influenced their comments on timing. As one participant noted, if the aim of the program was to address the collaborative relationship there may be a benefit from sessions being closer together. However, if the aim was to progress the project then time in between sessions becomes more important.

Online portals such as Basecamp and Slack were used by some programs for sharing resources and for participants to engage in group problem solving. Additional online resources enabled participants to follow up with extra reading as required. Several participants commented on the value of these resources. One commented on the need to send these resources out prior to the session. Participants reportedly underused the portal for peer networking and preferred email or phone calls with facilitators.

Participant feedback about program delivery had a strong focus on the experience and skills of facilitators. Facilitators varied in their approach to group engagement with participants describing a 'lecturing style' with a passive role for participants, to more interactive approaches to participants and their involvement.

Really dynamic, really great pair together... very engaging and very knowledgeable... and delivered it in a way that wasn't bland (Participant)

Participants also described differences in the ability of facilitators to identify and support those having problems or difficulty understanding theory. Where facilitators did not pick up on individual participant issues, the participant pair felt they were left to manage issues themselves. One participant noted facilitators routinely did not greet them as they entered the room at the beginning of the day as they appeared busy preparing the session. In contrast, other participants commented on the support received between sessions from their facilitators.

They had strong communication between sessions, mainly via e mail, which was perfect for me (Participant)

In contrast to the view that program success related to participant composition was the perspective that facilitator pair relationships are crucial. How well facilitators collaborated with one another and could model the processes they were trying to elicit in participants was seen by some as a key to program success. Participants commented on the degree that some facilitators worked well with each other and demonstrated collaboration. The experience of some facilitators feeling more successful with subsequent rounds of program delivery highlights the role of facilitator experience and confidence in success. Facilitators understood their relationship was important and was a collaboration model for participants. However, facilitator relationships needed dedicated time to develop and reflect on, above and beyond that provided in supervision, and this occasionally suffered as the demands of organising the program took priority.

Facilitators were allocated 7.5 days, but suggested this is inadequate for all the tasks required of the role, which included:

- Involvement in recruitment
- Liaison and relationship building with the PHN, especially prior to program delivery
- Ongoing meetings with CHF
- Communication to participants prior to and during the program
- Preparation of sessions
- Delivery of sessions
- Follow up with participants who missed sessions
- Supervision with Kings fund
- Facilitator review of session
- Involvement in formal evaluation

One facilitator estimated it took double the amount of time to deliver the first program. Clinician facilitators reported it was a challenge to find time in their schedule beyond the allocated time. Because of this, some consumer facilitators reported any slack typically fell to them. While some consumer facilitators had fewer time pressures than clinicians the extra time spent on tasks was not reflected in their remuneration. Further, this was also not always an effective way to model how to balance power relations and demonstrate working relationships between clinicians and consumers.

Regional participants participating via videoconference found it hard to stay engaged over the whole day and occasionally experienced connection loss and suggested they would have preferred face to face contact. Facilitators who delivered programs outside the region they lived or worked in found this a particular challenge. The need to build relationships to make the program work was important and was easier to do this where facilitators knew or could easily meet with stakeholders to assist recruitment and implementation. Facilitator pairs also benefitted from being able to meet easily to discuss and reflect on progress. Some facilitators who were based out of the state reported that they would 'piggy back' meetings with pairs or PHNs onto other activities they were involved in within that area. The challenge of non-local facilitators was compounded when sessions needed to be rescheduled. For interstate facilitators, the project costs do not always reflect the full expenses as they were often being cross-subsidised by other activities. Travel time and costs were reported to be significant for facilitators and participants travelling regionally and need to be considered in future regional programs.

Summary: Program Format

WHAT WORKED WELL

- **Face to face interactions**
- **Discursive and participative style of facilitation**
- **Facilitators who could model collaborative relationships and relationship building processes**
- **Facilitators who were able to identify issues and support participants**
- **Facilitators with lived experience as consumer and clinicians**

WHAT COULD BE IMPROVED

- **Adequate remuneration of facilitators for preparation, supervision and travel time (their own and participants)**
- **Session spacing to ensure maintain momentum (approximately 3 weeks) and without interruption of Christmas break**
- **Shortening length of days to allow for commute and participant fatigue**
- **Use of technology to record content for participants who miss sessions**

Content

When asked specifically about program content, the majority of participants valued the course content and the useful tools and resources supplied. In terms of what participants saw themselves using in future work, often mentioned were world café techniques, stakeholder mapping, power and conflict activities. Several participants remarked on the need to situate examples in some aspects of the course content to the Australian context. Facilitators described how they individually had tried to tailor these materials and felt that in the process had duplicated effort. Some suggested that CHF might have undertaken this process centrally prior to the program delivery to save time and duplication of effort for facilitators. One consumer commented on the relevance of the program content to indigenous and marginalized communities.

Very helpful resources however the big thing we didn't manage to include was socio inclusion and respect. The program takes no account for indigenous perspective and people who have had trauma. That wasn't in there ... you would need to update resources.

The majority of participants interviewed reported being unclear initially exactly what the program involved, and several remained unclear until the 2nd or 3rd of the five sessions. Many participants across cohorts initially believed the project would be a significant part of the program:

I could never understand what we were hoping to achieve in the end ... I think it was assumed that that was known by each pair before we went there and we didn't. (Provider participant)

Wasn't sure what it was, based on the description. I knew it was some sort of leadership but thought it would be a lot more practical work and really looking at what our project was (Provider participant)

Some participants who thought the project was a major focus of the program were disappointed their project did not progress as far as anticipated. These participants were not expecting the amount of out of session time required to progress their project and had difficulty managing this. Other program participants had a clearer understanding of the program focus on communication and relationship development processes and the role of the project in facilitating this.

The process was important... the process is the relationship and developing the relational skills and breaking down the power dynamics and barriers, and the project was the mean by which you do that (Provider participant)

[It was] more about building skills to have strong collaborative partnerships. Not just working with someone on a project and collaborating (Provider participant)

Even when participants understood the focus on relational skills a few were surprised by the 'depth of theory, depth of discussion and dialogue' that gave it a 'very applied and experiential' focus. A few participants commented on the need to make the connection between the theoretical collaboration content and the work of the project more explicit.

Facilitators saw the project as an important vehicle for exploring collaborative relationships. Facilitators commented that project completion was less important than a pair progressing their collaborative relationship while working on the project. One facilitator commented the 'projects were often set by the organisation, [or] the provider and then the consumer was co-opted' and suggested a pre-meeting between provider/clinician and consumer may be useful to jointly discuss the project. A summary of project categories, giving an indication only of the type of projects undertaken, is presented in Table 7.

TABLE 7: SUMMARY OF PROJECT CATEGORIES

PROJECT CATEGORIES
<ul style="list-style-type: none"> • Encouraging feedback from service users • Developing patient and family education on specific health/welfare issue • Involving consumers in program evaluation • Understanding patient/consumer perspectives on health/welfare issues • Developing and effective working with peer support networks • Consumer involvement in incident review • Developing new models of care • Consumer centric approach to service commissioning • Connecting with vulnerable communities • Consumer perspective on clinician roles • Supporting peer workers • Supporting informed consumer decision making in preventative health activities

Facilitators adapted the content of the session to meet the need of participants. The program as supplied by the King's Fund provided more content than was needed for sessions and allowed facilitators to pick and choose activities and slides relevant to the group. Facilitators varied in their comfort with exercises and a few remarked that the success of participant activities reflected this.

Facilitators from three areas invited guest speakers to sessions, as had been done in the King's Fund training, to discuss consumer and provider collaborations and found this a valuable addition. Another facilitator commented they did not have the contacts to organise this and felt that central support from CHF in identifying who to contact and how to do this would be beneficial.

A key issue identified by both participants and facilitators was the need for between-session participant coaching from facilitators. Some facilitators offered this, and participants found this very useful. Between-session coaching was a way of checking in with participants and reviewing their relationship and understanding of key concepts. It was recognised this approach would need an upfront commitment of time from pairs and would have remuneration implications.

Several programs ended their formal delivery with presentation by pairs, reflecting on their learning to date, which key stakeholders and sponsoring organisation were invited to. Despite this, a few participants commented on the sudden end to the program. Many participants expressed the need for a mechanism for post-program follow up such as peer networking, community of practice, chatroom, forum or follow up with facilitators to assist continuing development. Several participants and facilitators commented on the need to harness the enthusiasm of participants for future collaborative work. An ongoing community of practice, supported by CHF or locally by PHNs, could link pairs between locations and could be designed to support ongoing project work and applying collaborative methodologies.

Knowledge capture

The program included various mechanism for participants to reflect on and capture their learnings from each session. These included the creation of murals, written feedback and personal journals. At the end of each session facilitators collected anonymous feedback from participants about what to keep, discard, amend or create from the program from both an individual and pair perspective. This information was collated and fed back to participants at the next session. Two facilitators reported their use of a mural did not work well and felt participants did not engage with this form of reflection. A participant also commented on the mural lacking usefulness. One facilitator felt journals for participants to record their personal thoughts were generally not used by participants. Most facilitators undertook a debriefing after each session to capture and reflect on their own learning and to review the participant knowledge capture.

Knowledge capture data documentation was reviewed as part of the evaluation. Key themes from the knowledge capture over all sessions are presented in Table 8.

Summary: Program Content Summary

WHAT WORKED WELL

- **Content of sessions and practical activities**
- **Guest speakers in first session with assistance from CHF in identifying potential speakers and process**
- **Availability of online resources**

WHAT COULD BE IMPROVED

- **Making clear program objectives in EOI and initial program delivery**
- **Clarifying role of project within program**
- **Between session coaching for participants**
- **Post-program peer networking or community of practice**
- **Interactive facilitation style**
- **Contextualise facilitator resources to Australian context and address indigenous cultural perspectives**
- **Co-brand with sponsor organisations where possible**

TABLE 8: SUMMARY OF KEY KNOWLEDGE CAPTURE THEMES

KEEP	DISCARD	AMEND	INVENT
<ul style="list-style-type: none"> • dialogue/discussion/ listening conversations • 'why' questions • reflective practice • draw on others experience • respect • different ways of conflict resolution • ladder of inference • walk and talk • world cafe • sharing/being open • valuing unique perspectives • open mindedness • honesty/fun/friendliness • strengthening relationship • regular catch up • prompting people to share • revisiting objectives and expectations 	<ul style="list-style-type: none"> • self-doubt • impatience • being in control/ownership • assumptions • judgement/bias • competition • talking too much • fear of conflict/differences • ego • needing to act quickly • being task focussed • equating education with power • inward focus 	<ul style="list-style-type: none"> • more time on understanding problem • more time and approach to questioning • listening • speaking up more • more brainstorming • valuing others contribution • continually review relationship • address power imbalance • regular time together • define engagement • language used • time for reflection 	<ul style="list-style-type: none"> • new ways of working/ engaging/ communicating and reflecting • opportunities for new perspectives/engaging different voices • pair feedback processes • create learning environments • ways of addressing power imbalances • how to share learnings • new project • inclusive and culturally respectful leadership • build stories and examples of collaboration • access to new resources and tools for collaboration • keeping connected to share learnings

6.5. Impact

Interviewees were asked to reflect on the impact of the program for them and for sponsoring organisations. Most participants expressed the personal benefits of the program in terms of new skills, thinking and approaches to communication, collaboration and partnership. Examples of comments include:

I know that programs like this work. They change clinician behaviour, they change consumer behaviour and ultimately change the way people behave at the bedside (consumer participant)

Has changed the way I think about it [collaboration]... not just the business side of it but building the relationship (provider participant)

Made us realise we had to take a different approach to project development, collaborate more widely and listen, ask the right questions (provider participant)

Definitely the way the health system needs to go and health practitioners need to practice these relational skills (provider participant)

Learned some really great skills around collaboration that am now using in other areas of my life to advocate for myself and for others (consumer participant)

Several attributed the change in their approach to relationship building to a greater understanding of and ability to address power imbalances between clinicians/providers and consumers. For consumers this gave them greater confidence to speak up.

Has given me confidence that what I have to offer is valuable (consumer participant)

Disrupt[s] the power dynamic that exists between clinicians and consumers to provide better systems ... that meet the needs of consumers rather than what clinicians think consumers need (provider participant)

A facilitator commented that:

So many of the consumer engagement attitudes in organisations, in hospitals, in particular position the consumer as the problem and the clinician and service provider as naturally having the skills to do that work. What we have seen is this program is definitely more transformational for the clinician/service provider half, especially when you get experienced consumers coming into the program because these issue of power, conflict and influence and how you actually make things happen in a challenging hierarchical bureaucratic system are things that consumers working in consumer representatives roles are thinking about all the time.

A facilitator also commented the program is different to the 'typical' consumer development program on offer that are typically restricted to theory and often have little substantive consumer involvement. A few participants commented on the opportunity provided to network with PHN and other staff in their area. There were, however, a few negative responses to the program:

I kept thinking each time I went and leaving... that was horrible. I thought it was just my own process but by the last session ...two other people turned up ...that were in different states of distress. I thought I don't think this is just me, I think this has been a really difficult process (participant)

Facilitators and PHN staff commented on the need for tangible methods of measuring the program impact while acknowledging the difficulty of doing this in the area of collaboration. Measuring changes in attitudes to collaboration was seen as a possible way to evidence this.

Facilitators reported that most participants made progress with their project. However, the majority of projects were unfinished at the end of the program reflecting the type of topics selected required ongoing collaboration. Most agreed that project completion was not an appropriate measure of success. Several participant interviewees reported their collaborative pair work on the project was continuing beyond program completion. One PHN reported that project completion in an area relevant to PHN priorities was a potentially important impact consideration for them.

All types of program participants expressed the view the impact of the program on sponsoring organisations was unclear. Many believed this would emerge over time as they had more time to embed their skills or as the number of people undertaking the program from individual organisations increased. Although some questioned whether skilling up pairs would ever deliver a sufficiently large critical mass to fundamentally change practice within organisations.

Organisational benefits were remarked on at one sponsoring organisation where clear mechanisms to incorporate learnings from the program had been created. At this organisation, which sponsored several participants, senior directors were engaged and received progress reports from participants. A promotional video was also distributed throughout the organisation and a debrief session was planned at the end of the second cohort to review organisational involvement in the collaborative pairs program.

The evaluation of the trial indicates there were impacts at the individual level in changing perceptions of power and in the ability to engage, share and communicate ideas and experiences to identify problems and brainstorm possible solutions. The evaluation of organisational impact needs further investigation through sponsoring organisations in future iterations of the program.

Summary: Program Impact Summary

WHAT WORKED WELL

- **Participants developed new approaches to communication, collaboration and partnership**
- **Participants developed greater understanding of power imbalances**
- **Some consumer participants reported feeling more confident in voicing opinions**
- **Some participants made substantive progress in refining and initiating projects for future implementation**

WHAT COULD BE IMPROVED

- **Consider mechanisms for support for participants who experience difficulties during program**
- **Build sponsoring organisational impact assessment into future evaluations**

6.6. Future and sustainability considerations

All participants and facilitators saw the potential value and importance of this type of program. Participants were supportive of the program continuing in the future, but almost all qualified this with the need to make changes to the program format as outlined in the recommendations.

Assessing the program cost was not a deliverable included in the scope of this evaluation. However, it was clear that the program required significant in-kind contribution from PHNs and facilitators and took longer to implement than originally anticipated. This is not unusual for pilot programs. It is clear from the feedback that future iterations of the program will require substantial funding and senior leadership support and buy in from sponsoring organisations, whether they be PHNs or healthcare and community organisations.

Future programs need to harness the experience and knowledge of existing facilitators with the potential, as demand increases, to use participants who show particular interest and commitment to the broader agenda of system change. Existing facilitators can provide a possible avenue for modelling, mentoring and guiding program participants who demonstrate the capability to become facilitators. This approach would reduce the costs associated with training in the UK.

Future programs could also consider shared leadership models between facilitators and sponsoring organisations to support timely, direct decision making and communication. The question as yet to be answered is the ability of the program, in training a limited number of individuals, to produce the desired cultural change in organisations.

6.7. The evaluation approach

The Australian approach to evaluation of the trial is different to that undertaken of the Collaborative Pairs programs by the King's Fund. In the UK, the evaluation is integrated within the program with participants shaping the evaluation approach and evaluators seen as part of the process and capturing the impact of the process on the evaluators. This is seen as reducing the 'us and them' perception of the expert evaluator and those being evaluated. This approach mimics the breaking down of clinician/patient power imbalances in the Collaborative Pairs program.

The experiential feature of the Collaborative Pairs program is, by its very nature, difficult for evaluators to appreciate and this evaluation benefitted from exposure to a trial final presentation session and from direct discussion and experience of the process of reflection through the interview with the King's Fund. Future evaluations of the program would benefit from input into the evaluation design from facilitators and other key stakeholders such as sponsoring organisations.

Future evaluations would benefit from clearer mechanisms in place to collect data on participant demographics, session attendance and reason for drop out. Participant evaluation would be valuable in pre and post program assessment of attitudes to collaboration as well as post program format feedback. Evaluation design, if timeframes allowed, could also consider measuring organisational impact and culture change.

7. Conclusions and recommendations

The evaluation sought to assess the program's relevance, receptiveness and acceptability in the Australian context; effectiveness in building collaborative relationships; inform future implementation and build the evidence base. The program is seen as relevant and important in the Australian context. All participants saw the potential benefits of future program implementation with some changes to format and content contextualisation.

Some participants reported changed attitudes to collaborative working and communication and a greater understanding of existing power relationships. Changes to the program delivery as outlined in the recommendations may enable future program iterations to deliver these benefits to more participants. Introducing measures to assess attitudes to collaborative working relationships would complement qualitative data on participant benefits in future program evaluations.

The benefits to sponsoring organisations was unclear as the evaluation was confined to participant perspectives on this. Low numbers of participants from each sponsoring organisation restricted the evaluation of organisational impact. The time and number of participants undertaking the program required for cultural change to develop may limit the ability to determine organisational impact within a single program delivery period.

The concept of Collaborative Pairs was seen by many across PHNs, facilitator and participant cohorts as innovative and exciting. While the project did not progress at the pace that was initially envisaged after facilitator recruitment and training, this is not unusual for a pilot project. New processes and working relationships take time to be established. The trial provided substantial learnings in designing future iterations of the program. Based on the evaluation findings the following recommendations are made for future implementation.

Marketing and recruitment

1. Clarify program objectives, highlight experiential aspect of program and articulate anticipated benefits to participants and sponsoring organisations in marketing
2. Clarify time commitment to all program activities
3. Recruitment exclusion criteria to include pairs in current therapeutic relationship
4. Redefine role of project in program as a vehicle to explore collaborative work
5. Co brand with sponsoring organisation where possible
6. As part of recruitment assess commitment of sponsoring organisations providing participants
7. Use experienced facilitators as part of recruitment to model and explain program objectives
8. Provide forum for facilitators to meet applicants prior to confirmation of selection

Facilitation

9. Contextualize facilitators resources to Australian context
10. Develop facilitator peer support network
11. Remunerate facilitators according to time spent on additional administrative tasks and travel time

Program format

12. Introduce clear program and session objectives
13. Consider guest speakers to model desired outcome
14. Reduce interval between session to maximum 3 weeks
15. Reduce length of day for participants
16. Allow greater time for discussion through reducing didactic content
17. Provide between session participant coaching by facilitators
18. Investigate session recording/other mechanism for participants who miss sessions
19. Investigate mechanism for post program community of practice or peer support network

Evaluation

20. Record session attendance, participant background (clinician/manager, consumer, consumer leader) and project type and progress, and reason for drop out
21. Introduce pre and post measure of attitudes to collaborative working
22. Involve facilitators and key stakeholders (e.g. sponsoring organisations, CHF) in future design of evaluation
23. Evaluate the impact of programs located within direct provider organisations in future iterations of the program.

FIGURE 2: RECOMMENDATIONS AGAINST TRIAL STAGE



8. References

- Australian Commission on Safety and Quality in Health Care. 2011. Patient-centred care: Improving quality and safety through partnerships with patients and consumers. Sydney: Australian Commission on Safety and Quality in Health Care.
- Australian Commission on Safety and Quality in Health Care. 2017. Partnering with Consumers Fact Sheet. Sydney: Australian Commission on Safety and Quality in Health Care.
- Bath, J, and J Wakeman. 2015. "Impact of community participation in primary health care: What is the evidence?" *Australian Journal of Primary Care* 21:2-8.
- Consumer Focus Collaboration. 2001. The evidence supporting consumer participation in health. Canberra: Commonwealth of Australia.
- Consumers Health Forum of Australia. 2017a. Collaborative Pairs Australia: An overview. Canberra: Consumers Health Forum of Australia.
- Consumers Health Forum of Australia. 2017b. Collaborative Pairs Australia: Collaborative Pairs and National Health Reform. Canberra: Consumers Health Forum of Australia.
- Coulter, Angela, Sue Roberts, and Anna Dixon. 2013. Delivering better services for people with long-term conditions: Building the house of care. London: King's Fund.
- Damschroder, L.J., .. D.C. Aron, R.E. Keith, S.R. Kirsh, J.A. Alexander, and J.C. Lowery. 2009. "Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science." *Implementation Science* 4:50.
- Foot, C, H Gilburd, P Dunn, J Jabbal, B Seale, J Goodrich, D Buck, and J Taylor. 2014. People in control of their own health and care: The state of involvement. . London: The King's Fund.
- Gardner, K, H Dickinson, and K Moon. 2019. "Re-orienting health systems through a commissioning approach: Finding solutions for improved consumer engagement." *Health Research Policy and Systems* 17 (71).
- Gold, M, M Hossain, and A Mangum. 2015. "Consumer Engagement in Health IT: Distinguishing Rhetoric from Reality." *eGEMS (Generating Evidence & Methods to Improve Patient Outcomes)* 3 (1):18. doi: <http://doi.org/10.13063/2327-9214.1190>.
- Hibbard, JH, and J Greene. 2013. "What the evidence shows about patient activation: better health outcomes and care experiences; fewer data on costs." *Health Affairs* 32 (2):207-214.
- Janamian, T, L Crossland, and L Wells. 2016. "On the road to value co-creation in health care: the role of consumers in defining the destination, planning the journey and sharing the drive." *Medical Journal of Australia* 204 (7).
- Ocloo, J, and R Matthews. 2016. "From tokenism to empowerment: progressing patient and public involvement in healthcare improvement." *BMJ Quality and Safety* 25:626-632.
- Scholz, B, J Bocking, and B Happell. 2017. "How do consumer leaders co-create value in mental health organisations? ." *Australian Health Review* 41 (5):505-510.
- Spark, L, S Robinson, and H Dickinson. 2019. Collaborative Pairs Australia National Demonstration Trial: Review of existing evidence. Canberra: Public Service Research Group.
- Sweeney, L, A Halpert, and J Waranoff. 2007. "Patient-centred management of complex conditions can reduce costs without shortening life." *American Journal of Managed Care* 13:84-92.
- Weissman, Joel S, Michael L Millenson, and R Sterling Haring. 2017. "Patient-centred care: Turning the rhetoric into reality." *American Journal of Managed Care* 23 (1):e31-32.

