

**Southern Grampians Glenelg Primary Care Partnership  
Joint Venture Agreement**

between

**ASPIRE, a Pathway to Mental Health Inc (A0023269X)**

and

**Balmoral Bush Nursing Centre Inc (A0009226Z)**

and

**Brophy Family and Youth Services Inc (A0023744G)**

and

**Casterton Memorial Hospital**

and

**Coleraine District Health Service**

and

**Community Connections (Vic) Ltd (ACN 083 100 118)**

and

**Dartmoor and District Bush Nursing Centre Inc (A10733)**

and

**Glenelg Shire Council**

and

**Hamilton Community House Inc (A0026122L)**

and

**Heywood and District Memorial Hospital**

and

**Kyeema Centre Portland Inc (A0005518L)**

and

**Mulleraterong Centre Inc (A187)**

and

**Old Courthouse Community Centre Inc (A0016252P)**

and

**Otway Division of General Practice Inc (A0029224U)**

and

**Portland and District Community Health Centre Inc (A0019321F)**

and

**Portland and District Hospital**

and

**Portland Neighbourhood House Inc (A1137)**

and

**South West Access Network Inc (A0010905X)**

and

**Southern Grampians Shire Council**

and

**Western District Health Service**



and

**Otway Division of General Practice Inc**, an association incorporated under the *Associations Incorporation Act 1981*

and

**Portland and District Community Health Centre Inc**, an association incorporated under the *Associations Incorporation Act 1981*

and

**Portland and District Hospital**, a public hospital incorporated pursuant to the *Health Services Act 1988*

and

**Portland Neighbourhood House Inc**, an association incorporated under the *Associations Incorporation Act 1981*

and

**South West Access Network Inc**, an association incorporated under the *Associations Incorporation Act 1981*

and

**Southern Grampians Shire Council**, a body corporate established under the *Local Government Act 1989*

and

**Western District Health Service**, a public hospital incorporated pursuant to the *Health Services Act 1998*

**Whereas:**

- A Each party to this +agreement is a body corporate involved in the provision of +primary care services in the +catchment area.
- B In order to achieve meaningful integration, the +parties have come together to form the +Southern Grampians Glenelg Primary Care Partnership to enter into purchasing arrangements with +DHS which support effective and efficient delivery of +primary care services consistent with output reporting requirements of +DHS and accountability and reporting requirements of other funding sources.
- C The +parties to this +agreement share the values and objectives listed below:
- ?? The +Partnership is committed to the development of a high quality public health system that improves the health and well-being of the population of the Southern Grampians and Glenelg Shires and is responsive to the needs of service users.
  - ?? The development and implementation of the +Community Health Plan will identify the priority health and well-being needs of the

community in the +catchment area and will describe how the +primary care agencies providing services in the +catchment area will work with each other to respond to these needs.

- ?? The social model of health underpins the +Partnership decision-making and planning.
- ?? Consumers, carers and the community are encouraged and supported to participate in planning and decision-making.
- ?? The continuing involvement of small and specialist agencies is encouraged.
- ?? Effective collaboration and partnership will be achieved through the development of a shared sense of purpose and a high level of trust; effective teamwork and communication; the commitment of all partners; acceptance of difference and development of effective processes for decision-making.

- D Further, the +parties, through membership of the + Southern Grampians Glenelg Primary Care Partnership and this +agreement, will establish an accountability framework to ensure that vulnerable clients continue to access services appropriate to their needs.
- E The +contact agency being Western District Health Service has agreed to enter into the purchasing arrangements referred to in clause 3.1 and to act on behalf of the + Southern Grampians Glenelg Primary Care Partnership and its +members subject to this +agreement.
- F The + Southern Grampians Glenelg Primary Care Partnership will not engage in activities which undermine the specific brief or mission of member agencies.

## **1 Membership of the + Southern Grampians Glenelg Primary Care Partnership**

### **1.1 Initial Members**

The + Southern Grampians Glenelg Primary Care Partnership is an unincorporated joint venture consisting of the agencies which have signed this +agreement.

## 1.2 Further +members

Membership of the + Southern Grampians Glenelg Primary Care Partnership is open to any incorporated body which provides +primary care services in the +catchment area subject to the approval of a majority of +members at the Annual Meeting of the + Southern Grampians Glenelg Primary Care Partnership.

- ?? New members will support the values stated in this +agreement and endorsed by the + Southern Grampians Glenelg Primary Care Partnership.
- ?? New members will agree to participate in the development and implementation of approved projects and of the + Southern Grampians Glenelg Primary Care Partnership.
- ?? A dispute as to the admission of an agency as a new member will be referred to dispute resolution mechanism as per clause 14.

## 1.3 Service Linkage Protocols

The + Southern Grampians Glenelg Primary Care Partnership agrees that other +parties may become involved in the processes of partnership development, service coordination and service planning through signing a Service Linkage Protocol.

- ?? A Service Linkage Protocol is a formal statement setting out the purposes, goals, responsibilities and agreed working relationships between each of the +parties who agree to its terms. It is signed by each party but is not legally or financially binding.
- ?? +parties to a Service Linkage Protocol shall not have any voting rights but shall have the right to receive information and reports from the Executive Committee and may participate in +primary care development through membership of Task Groups as determined by the Executive Committee.

## 2 Term and Termination

- 2.1 Subject to sub-clause 2.3, this +agreement shall be for a term of 3 years from the +commencement date.
- 2.2 The Executive Committee may by resolution terminate this +agreement at any time.
- 2.3 A +member may terminate its participation in this +agreement by giving 6 months written notice to the Executive Committee. However, that +member will remain liable for its share of any costs incurred by the + Southern Grampians Glenelg Primary Care

Partnership or the +contact agency in properly carrying out its obligations under this +agreement or as authorised by the Executive Committee, for 6 months from the date of the notice having regard to the gross operational expenditure of each +member with respect to +primary care in the +catchment area.

2.4 On termination of this +agreement, the following shall apply:

- ?? Any debts outstanding by the + Southern Grampians Glenelg Primary Care Partnership or +contact agency in properly carrying out its obligations under this +agreement or as authorised by the Executive Committee shall be contributed to by +members as directed by the Executive Committee which shall act in an equitable manner having regard to the gross operational expenditure of each +member with respect to +primary care in the +catchment area.
- ?? Any assets of the + Southern Grampians Glenelg Primary Care Partnership remaining after debts are acquitted shall be distributed to +members, or sold, as directed by the Executive Committee which shall act in an equitable manner having regard to the gross operational expenditure of each +member with respect to +primary care in the +catchment area.
- ?? Any assets acquired by the +contact agency with funds provided by +members remaining after debts are acquitted shall be distributed to +members, or sold as directed by the Executive Committee which shall act in an equitable manner having regard to the gross operational expenditure of each +member with respect to +primary care in the +catchment area.

### **3 Contact Agency**

3.1 The +contact agency is appointed as the authorised agent of the + Southern Grampians Glenelg Primary Care Partnership to:

- ?? Enter into purchasing arrangements with +DHS and to purchase services from agencies which are external to the + Southern Grampians Glenelg Primary Care Partnership,
- ?? Enter into +contracts or other legal obligations,
- ?? Employ employees or engage consultants to do the work,
- ?? Hold on trust any grants, funds or assets of the + Southern Grampians Glenelg Primary Care Partnership and

to pay salaries, contractual payments or other expenses of the + Southern Grampians Glenelg Primary Care Partnership and to otherwise report on and co-ordinate the finances of the + Southern Grampians Glenelg Primary Care Partnership, including the investment of monies from time to time.

?? Act in other matters, as directed by the Executive Committee.

3.2 The +contact agency by signing this +agreement accepts this appointment and agrees to undertake all obligations of +contact agency as set out in this +agreement.

#### **4 Responsibilities of all +members of the + Southern Grampians Glenelg Primary Care Partnership**

4.1 Each +member of the + Southern Grampians Glenelg Primary Care Partnership agrees to undertake their obligations under this +agreement and shall:

?? Establish the Executive Committee as set out in clause 5.

?? Provide resources as directed by the Executive Committee.

?? Be aware of, and not act in, any conflict of interest.

?? Act in accordance with all applicable laws and in accordance with any purchasing arrangements entered into by the +contact agency with +DHS or other funding sources.

4.2 Each member of the + Southern Grampians Glenelg Primary Care Partnership acknowledges that it is severally liable and responsible for its obligations under this +agreement and agrees not to do any act or omit to do any act which may cause the +contact agency to be in breach of any purchasing arrangements or +contract entered into, or otherwise cause the +contact agency to be in breach of any legal obligations.

4.3 Subject to clause 18 the +members of the + Southern Grampians Glenelg Primary Care Partnership acknowledge that they share any +liability of the +contact agency which it incurs while acting on behalf of the + Southern Grampians Glenelg Primary Care Partnership in accordance with the terms of this +agreement unless that +liability arises from the negligence or wrong doing of the +contact agency. Such liability will be with regard to the gross operational expenditure of each +member with respect to +primary care in the +catchment area.

- 4.4 Each +member of the + Southern Grampians Glenelg Primary Care Partnership expressly waives its right to obtain a partition of any assets of the + Southern Grampians Glenelg Primary Care Partnership or held by the +contact agency on behalf of the + Southern Grampians Glenelg Primary Care Partnership.

## 5 Establishment of Executive Committee

- 5.1 The Executive Committee consisting of up to 11 people shall be elected by +members on an annual basis to serve a term of one year. The Executive Committee shall consist of nominees of the following +members and will reflect the range of +primary care services in the +catchment area :
- ?? up to 2 from local government agencies
  - ?? up to 2 from regional health agencies
  - ?? up to 2 from remote/small health agencies
  - ?? up to 2 from community agencies
  - ?? up to 2 from any other member agencies
  - ?? 1 community member
- 5.2 The election of the Executive Committee will take place at an Annual Meeting of all members. Each +member agency shall have one vote. A quorum for this meeting shall consist of not less than half the number of +members.
- 5.3 Voting shall be by a show of hands and in the event of a tied vote, the Chairperson of the meeting shall have, as well as a deliberative vote, a casting vote.
- 5.4 A +member agency may nominate another person as an alternate to attend in the absence of the elected representative. An alternate has all the powers of the member of the Executive Committee for whom they are appointed unless that person has already exercised those powers.
- 5.5 Members of the Executive Committee hold office for a period of one year from appointment or until they cease to be the nominated representative of a +member agency.
- 5.6 The +CEO's of +members appointed to the Executive Committee must ensure that the +Chairperson of the Executive Committee is informed of any change in nominee or alternate.
- 5.7 The role of the Executive Committee is to coordinate and provide management and guidance for the +contact agency and other members.

## **6 Chairperson and Secretary of Executive Committee**

- 6.1 The +Chairperson of the Executive Committee shall be elected from the members.
- 6.2 The + Executive Committee shall appoint an appropriately skilled person to act as Secretary. The Secretary shall not have any voting rights.

## **7 Quorum of Executive Committee**

- 7.1 The quorum for meetings of the Executive Committee shall be not less than 50% of those persons appointed to the Executive Committee.
- 7.2 If a quorum is not present within a half an hour after the time scheduled for the meeting, the meeting shall stand adjourned to the same time and place one week later.
- 7.3 If at the adjourned meeting, again no quorum is present, those persons appointed to the Executive Committee who are present shall constitute a quorum.

## **8 Procedure of Executive Committee**

- 8.1 The Executive Committee shall manage the implementation of the Primary Care Partnership Strategy for all its +members.
- 8.2 Subject to clause 8.3, any matter calling for resolution by the Executive Committee shall be determined by a show of hands and the resolution shall be carried if more members of the Executive Committee vote in favour of the resolution than against it. If the Executive Committee Members voting for the resolution and the number voting against it are equal, then the resolution is not carried.
- 8.3 If there is proposed a resolution which:
- ?? Amends this +agreement.
  - ?? Terminates this +agreement.
  - ?? Removes the +contact agency.
  - ?? Replaces the +contact agency.
  - ?? Terminates any legal obligation entered into by the +contact agency on behalf of the + Southern Grampians Glenelg Primary Care Partnership.
  - ?? Requires the +contact agency to commence legal proceedings.

- ?? Requires the appointment of an independent party to resolve an +issue.
- ?? Proposes suspension or termination of a +member's rights under this +agreement or payment of compensation by a +member,

then, the Secretary shall ensure that members of the Executive Committee are notified not less than 21 days prior to the meeting and shall follow the procedure set out in the *Associations Incorporation Act* for special resolutions as if the + Southern Grampians Glenelg Primary Care Partnership was incorporated under that Act, including the method of determining whether the resolution is passed or lost.

- 8.4 The Executive Committee shall meet not less than 6 times per year at a time and place determined by it.
- 8.5 The Secretary shall ensure that persons appointed to the Executive Committee are notified of meetings and the agenda for that meeting not less than 7 days prior to the meeting.
- 8.6 If not less than half the number of persons appointed to the Executive Committee request that an extraordinary meeting be called, they shall give notice to the Secretary of the business proposed to be transacted and the Secretary shall schedule a meeting within a reasonable time and notify the persons appointed to the Executive Committee. However, if a matter is proposed which falls within sub-clause 8.3, the Secretary must comply with the requirements of that sub-clause.
- 8.7 The Secretary shall ensure that minutes of meetings are recorded and sent to members of the Executive Committee (and any members co-opted pursuant to clause 1.3) within 10 days of any meeting.
- 8.8 The Executive Committee may establish any sub-committee or task group required to progress the work of the +Southern Grampians Glenelg Primary Care Partnership. The Executive shall establish its membership as required, with each sub-committee or task group to include at least one member of the Executive Committee. Membership of any sub-committee or task group is not limited to +member agencies and can include consumers and community members. Sub-committees and Task Groups shall report regularly to the Executive Committee.

## **9 Annual and Extraordinary Meetings**

- 9.1 An Annual Meeting of all +members will be held each calendar year with the first to be held within 3 months of the signing of this +agreement.
- 9.2 The purpose of the Annual Meeting will be to:
- ?? Elect the Executive Committee for the forthcoming twelve months pursuant to Clause 5.
  - ?? Review the management structure, procedure/performance of the Contact Agency and Executive Committee, and the Terms of Reference of the Partnership.
  - ?? Approve further +members to the +partnership pursuant to Clause 1.2
- 9.3 If not less than half the number of persons appointed to the Executive Committee or 50% of the +members request that an extraordinary meeting be called, they shall give notice to the Secretary of the business proposed to be transacted and The Secretary shall schedule a meeting within a reasonable time and notify all +members. At an Extraordinary meeting each +member agency shall have one vote and a quorum for this meeting shall consist of not less than half the number of +members.
- 9.4 Any matter calling for resolution by an Annual or Extraordinary Meeting shall be determined by a show of hands. The resolution shall be carried if more members of the Executive Committee vote in favour of the resolution than against it. If the + Members voting for the resolution and the number voting against it are equal, then the resolution is not carried. However, if a matter is proposed which falls within sub-clause 17.2, the vote must be unanimous.

## **10 Employees, Consultants and Contracts**

- 10.1 The Executive Committee shall determine whether consultants or staff are required to assist in implementing decisions of the Executive Committee.
- 10.2 If the Executive Committee determines that staff should be employed or consultants engaged, it shall direct the +contact agency as to the process to be followed and the +contact agency shall employ the staff as its employees or engage the consultants, as the case may be.
- 10.3 All + Southern Grampians Glenelg Primary Care Partnership +members shall indemnify the +contact agency for any +liability to

an employee or consultant employed or engaged by the +contact agency except insofar as the +liability arises from the wrong doing or negligence of the +contact agency.

- 10.4 Each +member of the + Southern Grampians Glenelg Primary Care Partnership shall share the cost as determined by the Executive Committee which shall act in an equitable manner having regard to the gross operational expenditure of each +member with respect to +primary care in the +catchment area.

## **11 Contracts**

- 11.1 Each +member of the + Southern Grampians Glenelg Primary Care Partnership acknowledges that the +contact agency is expressly empowered to enter into and manage any +contractual arrangement authorised by the Executive Committee.
- 11.2 Each +member of the + Southern Grampians Glenelg Primary Care Partnership shall share responsibility for the payment of any monies due under any +contractual arrangement entered into by the +contact agency in accordance with this +agreement.

## **12 Replacement of +contact agency**

- 12.1 The +contact agency may resign as +contact agency by giving not less than 2 months written notice by its +CEO to all +members of the + Southern Grampians Glenelg Primary Care Partnership.
- 12.2 As soon as practicable thereafter, and in accordance with clause 8.3, the Executive Committee shall meet and appoint a new +contact agency and amend this +agreement accordingly.
- 12.3 The Executive Committee may at any time replace the +contact agency in accordance with clause 8.3.

## **13 Intellectual property in confidential information**

- 13.1 The +members of the + Southern Grampians Glenelg Primary Care Partnership shall treat +confidential information as confidential, unless this +agreement expressly requires disclosure of that information.
- 13.2 No +member of the + Southern Grampians Glenelg Primary Care Partnership shall release any +confidential information relating to the + Southern Grampians Glenelg Primary Care Partnership or a member unless the Executive Committee or that +member (respectively) agree in writing to that disclosure.
- 13.3 +Members of the + Southern Grampians Glenelg Primary Care Partnership shall ensure that their employees and agents are aware of this obligation to keep +confidential information confidential.

13.4 It is acknowledged that the +contact agency is an agency to which the *Freedom of Information Act* applies and that information provided to it may require disclosure. However, the +contact agency agrees that if it receives a request which relates to +confidential information of:

?? A +member

?? The + Southern Grampians Glenelg Primary Care Partnership

it will advise the +member or the Executive Committee (as the case may be) and jointly decide whether to release the information or not.

13.5 In the event that legal costs or other costs are incurred by the +contact agency, the +members of the + Southern Grampians Glenelg Primary Care Partnership shall contribute to those costs as determined by the Executive Committee except if these costs were incurred by the negligence or wrong doing of the +contact agency.

#### **14 Dispute resolution**

14.1 If the +parties to this +agreement are unable to agree on an +issue, then any party may, by written notice to the Chairperson, refer the +issue to Executive Committee for resolution.

14.2 The Chairperson shall forthwith send written notice to all +members of the + Southern Grampians Glenelg Primary Care Partnership Executive Committee notifying them of the substance of the +issue and calling a meeting of the Executive Committee not less than 14 and no more than 21 days after receipt of the notice.

14.3 At the meeting called pursuant to clause 15.2, the Executive Committee shall act in good faith and attempt to resolve the +issue.

14.4 If the +issue is not resolved, then it shall be referred to a person:

?? Who is appropriately skilled and knowledgeable in the area.

?? Approved by not less than 75% of the Executive Committee.

14.5 The person chosen pursuant to clause 15.4 shall be charged with the task of resolving the +issue and his or her decision shall be final.

14.6 Until the +issue is resolved, the +parties agree to perform all obligations under this +agreement.

## **15 Failure to perform obligations**

- 15.1 If a +member of the + Southern Grampians Glenelg Primary Care Partnership fails to perform its obligation under this +agreement, for any other reason than +force majeure, then any +member of the + Southern Grampians Glenelg Primary Care Partnership may notify the Chairperson of the Executive Committee who shall:
- ?? Notify the +member alleged to be in default.
  - ?? Give notice of a meeting of the Executive Committee as set out in clause 8.3.
- 15.2 At the meeting called pursuant to clause 15.1, the Executive Committee shall give a representative of the member alleged to be in default an opportunity to hear and respond to the allegations either orally or in writing.
- 15.3 After the +member has been given an opportunity to respond, the Executive Committee (but not the +member alleged to be in default) shall determine whether that +member should have its rights suspended or terminated under this +agreement.

## **16 Legal costs and stamp duty**

The legal costs associated with the preparation of this +agreement and the stamp duty (if any) upon this +agreement shall be met from the +DHS +Primary Care Partnership grant.

## **17 Charges and Fees, Trust Account**

- 17.1 The Executive Committee shall, at its first meeting after the +commencement date, set an annual administration fee which shall be allocated from the +DHS +Primary Care Partnership grant.
- 17.2 If the Executive Committee shall require additional contributions from +members on account of expenses incurred by the +contact agency on behalf of the + Southern Grampians Glenelg Primary Care Partnership, recommendations for such fees established with regard to the gross operational expenditure of each +member with respect to +primary care in the +catchment area shall be made to an extraordinary meeting of the total membership as set out in clause 9.3. Such fees as agreed by vote of the +members present are payable within 7 days of receipt of an invoice from the +contact agency.
- 17.3 The +contact agency shall administer the finances of the + Southern Grampians Glenelg Primary Care Partnership through a special purpose trust fund and shall cause the fund to be audited as required by law.

## 18 Insurance

- 18.1 Each +member will be a Named Insured under the +DHS Healthcare Agency Insurance Program in accordance with the conditions of the +DHS Consortium Service Agreement.
- 18.2 Local government +members of the Partnership will be covered under the DHS insurance program while carrying out the activities under the Primary Care Partnership Health Services Agreement. The insurance policies extended to include Local Government +members are:
- ?? Combined Public Liability/Medical Malpractice
  - ?? Combined Professional Indemnity/Directors & Officers Liability
- 18.3 Protection against liability will only cease if +members act beyond the scope of the activities specified and agreed in the + Community Health Plan.

## 19 Notice

- 19.1 Each +member shall advise the +CEO of the +contact agency of its address for service of any notices required under this +agreement.
- 19.2 Address for service of any notice to the +CEO of the +contact agency is:
- Chief Executive Officer  
Western District Health Service  
PO Box 283  
**HAMILTON VIC 3300**  
Fax: 5571 0350  
Email: [ceo@wdhs.net](mailto:ceo@wdhs.net)
- 19.3 Any notice required to be served under this +agreement shall be regarded as being sufficiently served if:
- ?? Sent by facsimile machine to the facsimile number noted in clause 19.2 or as notified in writing from time to time by any party. The facsimile notice shall be deemed to have been served on the date and at the time of transmission on a normal business day in Victoria subject to the said notice being transmitted from the sending facsimile machine and answer back from the receiving machine having been received by the sending machine. If such transmission and answer occurs other than during normal +business hours on a normal +business day in

Victoria, the notice shall be deemed to have been served at 9 am the next following +business day.

?? Forwarded by pre-paid certified mail addressed to a party at the address provided under clause 19.2 or as notified from time to time to the other party. Pre-paid certified mail shall be deemed to have been served 2 +business days after the date of posting.

?? Sent by email to the email address noted in clause 19.2 or as notified in writing from time to time by any party. The email notice shall be deemed to have been served on the date and at the time of transmission on a normal business day in Victoria subject to the said notice being transmitted from the sending machine and answer back from the receiving machine having been received by the sending machine. If such transmission and answer occurs other than during normal +business hours on a normal +business day in Victoria, the notice shall be deemed to have been served at 9 am the next following +business day.

## **20 Entire agreement**

The +parties agree that this is the whole agreement and any representations previously made are of no legal effect.

## **21 Variation**

This +agreement may only be varied by agreement in writing and signed by all +members of the + Southern Grampians Glenelg Primary Care Partnership or by resolution in accordance with clause 8.3.

## **22 Assignment**

No party may assign its rights or obligations under this +agreement without the agreement in writing of all +parties prior to assignment.

## **23 Interpretation**

In this +agreement, unless the contrary intention appears:

?? Headings are for convenient reference only and have no effect in limiting or extending the language of the provisions to which they refer.

?? A reference to a clause or sub-clause is a reference to a clause or sub-clause of this +agreement.

?? Words in the singular number include the plural and vice versa; words importing a gender include all other genders.

?? A reference to a day, a week or a month means a calendar day, a calendar week or a calendar month respectively provided that where the last day of any period prescribed for the doing of any action falls on a day that is not a working day, the action may be done on the first +business day following that day.

**24 Governing law**

This +agreement shall be governed by and construed according to the laws of the State of Victoria.

## Definitions

<i>agreement</i>	means this agreement.
<i>business day</i>	means any day on which the Commonwealth Bank is open for business in Hamilton.
<i>business hours</i>	means between 9 am and 5 pm.
<i>catchment area</i>	means the area encompassed by the Glenelg and Southern Grampians Shires.
<i>CEO</i>	means Chief Executive Officer (by whatever name) of a +member.
<i>consortium service agreement</i>	means the funding and service agreement between DHS and the + Southern Grampians Glenelg Primary Care Partnership
<i>contact agency</i>	means Western District Health Service or any successor body appointed pursuant to clause 12.
<i>commencement date</i>	means the date on which the + Southern Grampians Glenelg Primary Care Partnership commenced implementation of the Primary Care Strategy.
<i>community health plan</i>	the tool agreed between DHS and the + Southern Grampians Glenelg Primary Care Partnership for negotiating and implementing change in the +primary care sector in the Southern Grampians and Glenelg Shires
<i>confidential information</i>	means, in relation to both the + Southern Grampians Glenelg Primary Care Partnership and its +members, information :  ?? That is by its nature confidential or  ?? Which a party ought reasonably to know is confidential or a party has designated as confidential.  and includes information relating to:  ?? The financial position of any of the +parties and the + Southern Grampians Glenelg Primary Care Partnership (including information relating to assets and liabilities).

	<p>?? Management practices of the +parties or the + Southern Grampians Glenelg Primary Care Partnership.</p>
<p><i>contracts or +contact</i></p>	<p>means any obligation entered into by the</p>
<p><i>contractual obligations</i></p>	<p>agency on behalf of the + Southern Grampians Glenelg Primary Care Partnership in the proper performance of its obligations under the +agreement or entered into at the direction of the Executive Committee.</p>
<p><i>DHS</i></p>	<p>means the Secretary, Department of Human Services.</p>
<p><i>force majeure</i></p>	<p>means a cause beyond the reasonable control of a +member and occurs if all of the following conditions are satisfied:</p> <ul style="list-style-type: none"><li><p>?? The failure or delay arose from a cause beyond reasonable control affecting the +member.</p></li><li><p>?? The +member took all reasonable precautions against that cause and did its best to limit its consequences. This does not require the +member to settle a labour dispute if, in the member's opinion, that is not in its best interests.</p></li><li><p>?? The +member gave the other +members notice of the cause beyond reasonable control as soon as practicable after becoming aware of it.</p></li></ul>
<p><i>issue</i></p>	<p>means an issue, matter or thing, the subject of or concerning this +agreement.</p>
<p><i>liability</i></p>	<p>means any legal or financial liability acquired by the +contact agency on behalf of the + Southern Grampians Glenelg Primary Care Partnership in the proper performance of its obligations under this +agreement or acquired by the direction of the Executive Committee.</p>
<p><i>members</i></p>	<p>means the signatory members to this +agreement and any agency admitted to membership pursuant to clause 1.2.</p>

*partnership or Southern Grampians* means the unincorporated joint venture vehicle & *Glenelg Primary Care Partnership* established by this +agreement

*party* means the signatories to this +agreement

*primary care* means those services which address prevention, early intervention and health promotion and impact on maintaining people's optimum health and wellbeing and which may be funded by DHS including:

- ?? HACC funded services
- ?? aged care assessment services
- ?? linkages
- ?? respite
- ?? community health services
- ?? Healthstreams
- ?? women's health
- ?? family planning
- ?? innovative health services for homeless youth
- ?? alcohol and drug services
- ?? dental services
- ?? psycho-geriatric assessment and treatment services
- ?? mental health services
- ?? family and youth services
- ?? maternal and child health services
- ?? domestic violence prevention
- ?? neighbourhood houses
- ?? disability services
- ?? Koori health
- ?? sexual assault services

Executed by the +parties as an agreement.

**The Common Seal of ASPIRE A** )  
**Pathway to Mental Health Inc** was )  
hereunto affixed in accordance with )  
its rules in the presence of: )

.....  
President

.....

**The Common Seal of Balmoral Bush** )  
**Nursing Centre Inc** was hereunto )  
affixed in accordance with its rules in )  
the presence of: )

.....  
President

.....

**The Common Seal of Casterton** )  
**Memorial Hospital** was hereunto )  
affixed in accordance with its by-laws )  
in the presence of: )

.....  
Chairperson

.....

**The Common Seal of Coleraine and District Hospital** was hereunto affixed in accordance with its by-laws in the presence of:

..... Chairperson

.....

**The Common Seal of Community Connections (Vic) Ltd** was hereunto affixed in accordance with its articles of association in the presence of:

.....

Director

.....

Secretary

**The Common Seal of Dartmoor and District Bush Nursing Centre Inc** was hereunto affixed in accordance with its rules in the presence of:

.....

President

.....

**The Common Seal of Glenelg Shire** )  
**Council** was hereunto affixed this )  
day of 1999 in the )  
presence of: )

.....  
Councillor

.....  
Councillor

.....  
Chief Executive Officer

**The Common Seal of Hamilton** )  
**Community House Inc** was hereunto )  
affixed in accordance with its rules in )  
the presence of: )

.....  
President

.....

**The Common Seal of Heywood and** )  
**District Memorial Hospital** was )  
hereunto affixed in accordance with )  
its by-laws in the presence of: )

.....  
Chairperson

.....

**The Common Seal of Kyeema Centre  
Portland Inc** was hereunto affixed in  
accordance with its rules in the  
presence of:

.....  
President

.....

**The Common Seal of Mulleraterong  
Centre Inc** was hereunto affixed in  
accordance with its rules in the  
presence of:

.....  
President

.....

**The Common Seal of Old Courthouse  
Community Centre Inc** hereunto  
affixed in accordance with its rules in  
the presence of:

.....  
President

.....

**The Common Seal of Otway Division** )  
**of General Practice Inc** was hereunto )  
affixed in accordance with its rules in )  
the presence of: )

.....  
President

.....

**The Common Seal of Portland and** )  
**District Community Health Centre** )  
**Inc** was hereunto affixed in )  
accordance with its rules -laws in the )  
presence of: )

.....  
President

.....

**The Common Seal of Portland and** )  
**District Hospital** was hereunto )  
affixed in accordance with its by-laws )  
in the presence of: )

.....  
Chairperson

.....

**The Common Seal of Portland** )  
**Neighbourhood House Inc** was )  
hereunto affixed in accordance with )  
its rules in the presence of: )

.....  
President

.....

**The Common Seal of South West** )  
**Access Network Inc** was hereunto )  
affixed in accordance with its rules in )  
the presence of: )

.....  
President

.....

**The Common Seal of Southern** )  
**Grampians Shire Council** was )  
hereunto affixed this day of )  
1999 in the presence of: )

.....  
Shire President

.....  
Councillor

.....  
Chief Executive Officer

**The Common Seal of Western** )  
**District Health Service** was hereunto )  
affixed in accordance with its by-laws )  
in the presence of: )

.....  
Chairperson

.....

**The Common Seal of Brophy Family** )  
**and Youth Services Inc** was hereunto )  
affixed in accordance with its rules in )  
the presence of: )

.....  
President

.....

## PROVIDER PARTICIPATION STRATEGY

### Vision

Building ownership of the primary care reforms through ongoing involvement of service providers in the work of the Partnership.

**Endorsed:** June 6<sup>th</sup> 2001

### 1. SUMMARY

The Southern Grampians & Glenelg Primary Care Partnership recognizes the skills and experience of professionals living and working in the district. Implementation of the primary care reforms will be carried out through a series of projects and staffed by appointing or sub-contracting professionals directly to these projects. Service providers and management will be involved through participation in work groups.

This document outlines the strategic and operational plan for staffing and implementation of the primary care reforms. It should be read in conjunction with the Southern Grampians & Glenelg Primary Care Partnership Community Health Plan.

### 2. VALUES

The Southern Grampians & Glenelg Primary Care Partnership is committed to:

- ?? actively pursuing primary care reform through partnership with agencies and service providers in the catchment area and reflecting the diversity of perspective and need in the community
- ?? encouraging the participation of a range of service providers, in order to reflect the diversity of perspective and service types within the Partnership
- ?? identifying and overcoming barriers to service provider participation
- ?? supporting effective participation, which requires commitment and leadership from the management of member agencies
- ?? advocating that the internal agency policies and procedures support and encourage service providers to be involved
- ?? providing adequate resources to ensure service provider participation can be valuable, meaningful and effective
- ?? recognizing that service provider skills, contributions and time are valuable
- ?? building the skills of local service providers
- ?? recognizing that agencies have varying capacity to provide input and developing innovative means to involve all agencies and service providers in the work of the Partnership

### 3. GOALS

To involve a broad range of individuals from agencies within the district in the work of the Primary Care Partnership.

- ?? Encouraging broad membership of the Primary Care Partnership through the Joint Venture Agreement

- ?? Developing Service Linkage Protocols to broaden the participation of all agencies providing services to the population of Southern Grampians and Glenelg shires, including local agencies not signatories to the Joint Venture Agreement and regional or statewide, specific interest agencies
- ?? Involve relevant management and service providers from primary care agencies in PCP activities through involvement in work groups, reference groups and advisory panels
- ?? Sub-contract appropriately skilled service providers from agencies in the district to carry out project work as required by the PCP

#### 4. KEY OBJECTIVES

##### 4.1 Communication

- ?? To provide accessible information to agencies and service providers to encourage their active participation in primary care reform
- ?? To develop and implement effective communication processes between member agencies, service providers involved in work groups, etc and staff of the Primary Care Partnership
- ?? To develop an effective team structure for staff working for the Primary Care Partnership

##### 4.2 Accountability

- ?? To develop clear and transparent guidelines and procedures which ensure accountability for the work of the Primary Care Partnership staff to member agencies through the Executive Committee.
- ?? To ensure equitable selection and support processes for all staff working with the Primary Care Partnership
- ?? To provide required equipment and other resources to ensure staff are able to carry out the tasks required of them

##### 4.3 Planning, Quality Improvement & Evaluation

- ?? To encourage the active involvement of primary care service providers in policy development, strategic planning and implementation of the plans and policies
- ?? To encourage the active involvement of service providers in evaluation, quality improvement and development of a self-assessment tool for the Primary Care Partnership

##### 4.3 Training and Support

- ?? To provide staff with appropriate training and support where required, to enable their participation in the work of the Primary Care Partnership.

**5. OPERATIONAL PLAN****5.1 Communication****?? To provide accessible information to agencies and service providers to encourage their active participation in primary care reform**

## PCP Tasks

- Circulate draft documents - Joint Venture Agreement and Service Linkage Protocols, to agencies
- PCP Bulletin to keep service providers informed, identify areas of available project work
- Maintain register of projects to be implemented by the PCP
- Maintain register of individuals (skills, experience and availability) interested in project work
- Develop Service Agreements with agencies for the sub-contracting of service providers to carry out PCP projects

## Agency Tasks

- Negotiate with management on membership of the PCP
- Distribute PCP Bulletin to staff within the agency
- Support agency staff interested in working with the Primary Care Partnership

**?? To develop and implement effective communication processes between member agencies, service providers involved in work groups, etc and staff of the Primary Care Partnership**

## PCP Tasks

- Roles and responsibilities of the Executive Committee detailed in the Joint Venture Agreement
- Develop terms of reference for work groups as required
- PCP staff to ensure minutes, working documents, etc are circulated to relevant persons
- Establish a PCP intranet to support the work of groups and project staff

## Agency Tasks

- Provide feedback to assist in the development of effective processes
- Support interested staff and provide access to resources as far as possible to facilitate their involvement

**?? To develop an effective team structure for staff working for the Primary Care Partnership**

## PCP Tasks

- Monthly team meetings for sharing of information
- Develop communication and reporting structure with Executive Officer

- o PCP staff assigned to work groups as required to facilitate effective reporting structure and coordination of activities

## **5.2 Accountability**

- ?? To develop clear and transparent guidelines and procedures which ensure accountability for the work of the Primary Care Partnership to member agencies through the Executive Committee.**

### PCP Tasks

- o Summary of Executive Committee meetings provided to all agencies through the PCP Bulletin
- o To provide information to service providers about opportunities for participation in work groups and process for nomination and selection
- o Develop clear position descriptions, project briefs and Terms of Reference for groups
- o Reporting structure to Executive Committee - monthly - from work groups and on projects
- o Develop annual budgets and monthly financial reporting processes to support staff in managing their work

### Agency Tasks

- o Nominate representatives to the Executive Committee and work groups
- o Nominate staff and/or management representatives to attend Forums and the Annual Meeting
- o Provide constructive feedback to improve accountability

- ?? To ensure equitable selection and support processes for all staff working with the Primary Care Partnership**

### PCP Tasks

- o Develop clear guidelines for selection, complaints and feedback processes
- o Provide appropriate supervision and reporting mechanisms

- ?? To provide required equipment and other resources to ensure staff are able to carry out the tasks required of them**

### PCP Tasks

- o Provide access to computer workstations and required programs
- o Provide mobile phones for the duration of the project(s) as required
- o Establish a network of offices with electronic communication including video conferencing where possible

### Agency Tasks

- o Provide access to resources (fleet vehicles, office space, administrative support, etc) if possible to enable PCP staff to carry out work for the PCP

### **5.3 Planning, Quality Improvement & Evaluation**

#### PCP Tasks

- Encourage the development of projects and activities which contribute to quality assurance and service development
- To conduct regular meetings or forums, relevant to particular issues or projects to enable input in ongoing service development and planning
- Seek feedback from service providers involved in work groups and sub-contracted for project work about processes to feed into the PCP self evaluation
- Develop evaluation of outcomes for the projects associated with activities in achieving PCP goals

#### Agency Tasks

- Encourage and support staff to be involved in planning, evaluation and projects
- Develop internal planning and participation processes to expand involvement to include all staff

#### Statewide Tasks

- DHS Central Office to support the development of guidelines for self-evaluation tools

### **5.4 Training and Support**

#### PCP Tasks

- Maintain a Resource Library of relevant literature to support PCP work
- Provide orientation for all service providers involved in work groups and when sub-contracted for project work
- Develop joint policies on the training of staff in member agencies around the principles and strategies of Primary Care Partnerships
- Promote the availability of relevant training courses

#### Agency Tasks

- Nominate staff member(s) to act as mentors and provide support and encouragement to other staff within the agency
- Support staff to attend relevant training courses

#### Statewide Tasks

- DHS to carry out relevant skills audits
- DHS to provide workshops and training relevant to PCP activities

**SOUTHERN GRAMPIANS & GLENELG PRIMARY CARE PARTNERSHIP**  
**CARER AND CONSUMER PARTICIPATION STRATEGY**  
**2001 - 2004**

**Our Vision: Consumers, carers and the community are able to participate in planning and decision-making and are empowered to affect the outcome of the process**

**Endorsed:** June 6<sup>th</sup> 2001

## **1. INTRODUCTION**

A **consumer** is someone who is on the receiving end of services. The term can be used to refer to individual clients, carers, consumer groups and community groups. The term "consumer" distinguishes the users of services from professionals and others providing services. Although professionals can also be consumers of services, their knowledge and experience makes this a different experience and limits their ability to represent the broad range of consumer groups.

Consumers vary in their backgrounds and opinions and as individuals, consumers will speak their own personal opinions. There is no single consumer view but probably as many views as there are consumers. What they share is the direct experience of the health and community services systems. What they experience is the end result that all the planners, policy makers, administrators, directors and professionals have helped to create.

Participation is the process by which people are enabled to become actively and genuinely involved in defining the issues of concern to them, in making decisions about factors that affect their lives, in developing and implementing policies, in planning, developing and delivering services and in taking action to achieve change. Participation includes a range of formal and informal activities. Consultation is one form of participation by which individuals or groups seek the views of others about issues or services.

## **2. VALUES**

- ?? Consumer, carer and community participation is an integral component of all primary care services.
- ?? Participation is based on dignity and respect for all individuals.
- ?? High quality and responsive services can best be achieved through partnership with consumers and carers.
- ?? All individuals will have varied experiences, so processes for participation will encompass this broad range.
- ?? Development of partnerships with different sectors of the community will assist in addressing structural issues consistent with a social model of health.
- ?? Any individual has the right to choose the level at which they participate, or not to participate.
- ?? Consumers are better informed on which factors impact on the use or non-use of services and can have common sense ideas about service delivery that can make the difference between success and failure.

- ?? Consumers are in the best position to ensure the right questions are asked and that the results are presented clearly.
- ?? Service planning must consider both the needs of the current service users and the needs of the wider community.
- ?? Effective consumer/community participation demands a commitment of leadership, resources, skills and adequate time.
- ?? Community skills, contributions and time are valuable.

### 3. GOAL

The Southern Grampians & Glenelg Primary Care Partnership will ensure consumer, carer and community participation is built in to all activities to plan and develop a coordinated network of primary care services that are relevant to the needs of all sectors in the community and to enhance the capacity of the primary care sector to engage with consumers, carers and the community.

### 4. OBJECTIVES

#### 4.1 Communication

- ?? To provide relevant and understandable information to consumers, carers and the community to assist their active participation in primary care service development.
- ?? To prepare and distribute a plain English version of the Community Health Plan on an annual basis
- ?? To give feedback to individuals and the community on the outcomes of their participation
- ?? To develop improved access to better information for consumers of primary care services.
- ?? To identify and work with specific communities and interest groups
- ?? To increase consumer confidence about privacy and confidentiality of personal information across the primary care system.

#### 4.2 Accountability

- ?? To formalize the structure of the Community Participation Workgroup
- ?? To develop a charter of consumer rights and responsibilities in consultation with consumers and carers.
- ?? To ensure consumers are engaged in decision making processes at least equally with other stakeholders, and that it can be demonstrated that consumer perspective influences the decisions made.
- ?? To develop a reporting framework for the PCP and member agencies that includes reporting on consumer/carers/participation within planning, service delivery and evaluation.

#### 4.3 Planning, Quality Improvement & Evaluation

- ?? To ensure evaluation of the Community Participation Strategy is built in to the PCP self-assessment tool

- ?? To build on relationships and mechanisms for consumer and community participation that already exist.
- ?? To encourage the active involvement of consumers in accreditation and quality improvement initiatives of the PCP

#### 4.4 Training and Support

- ?? To provide consumers, carers and community members with training and support to assist their active participation in primary care
- ?? To develop an awareness and training program for primary care service providers to support the development meaningful consumer/carer/community participation.

## 5. OPERATIONAL PLAN

### 5.1 Communication

- ?? To provide relevant and understandable information to consumers, carers and the community to assist their active participation in primary care service development.
  - o To involve as many people as possible in the Community Participation Workgroup
  - o To develop clear Terms of Reference, roles and responsibilities for the Community Participation Workgroup.
  - o To conduct regular meetings or forums at locations throughout the Southern Grampians and Glenelg Shires.
  - o Prepare all information in plain English
- ?? To prepare and distribute a plain English version of the Community Health Plan on an annual basis
  - o The Community Participation Workgroup to coordinate development of the plain English Community Health Plan
  - o The first plain English Community Health Plan to be available July 2001
  - o Distribution of the plain English Community Health Plan to be throughout the community
  - o Consumer feedback to be sought on the plain English Community Health Plan
- ?? To give feedback to individuals and the community on the outcomes of their participation
  - o All activities and reports of the PCP to include information on consumer/community participation/consultation and how the process has contributed to outcomes
- ?? To develop improved access to better information for consumers of primary care services.
  - o Involve the Community Participation Workgroup and a broad range of consumers and carers in the development of the information contained in the service database to ensure it meets consumer needs and is user friendly
  - o Coordinate consumer feedback on the Better Health Channel and provide to DHS through the Community Participation Workgroup
- ?? To identify and work with specific communities and interest groups

- Identify chronic illness support groups in the catchment and link them into the health promotion and chronic disease management strategies
  - Liaise with Koori organisations and their members to improve their participation in the Primary Care Partnership
  - Develop consumer/carer participation and consultation strategy within the Primary Mental Health and Early Intervention program development
- ?? To increase consumer confidence about privacy and confidentiality of personal information across the primary care system.
- Involve consumers in work groups to develop information management and record management for primary care services

## 5.2 Accountability

- ?? To formalize the structure of the Community Participation Workgroup
- Terms of Reference for the Workgroup developed and endorsed by the Primary Care Partnership
  - Roles and responsibilities of Workgroup members defined
  - Workgroup to develop a detailed work plan including time frames
  - Recruitment and administrative support processes developed
- ?? To develop a charter of consumer rights and responsibilities.
- Public launch of the draft Consumer Charter and development of a consultation and feedback process
  - Primary care agencies to seek feedback on the draft Consumer Charter from their consumers
- ?? To ensure consumers are engaged in decision making processes at least equally with other stakeholders, and that it can be demonstrated that consumer perspective influences the decisions made.
- To ensure representation of consumers, carers and the community on key PCP committees.
  - To develop transparent and equitable selection and support processes for consumer participants in PCP activities.
  - Liaison with the DHS Consumer Advisory Committee through the nominated regional representative
- ?? To develop a reporting framework for the PCP and member agencies that includes reporting on consumer/carer/participation within planning, service delivery and evaluation.
- Provide training to assist providers to engage appropriately with consumers and carers
  - Develop protocols and templates to guide participation processes

### 5.3 Planning, Quality Improvement & Evaluation

- ?? To ensure evaluation of the Community Participation Strategy is built in to the PCP self-assessment tool
  - o Develop a work plan for implementation of the strategy with time lines, key performance indicators and risk management plans identified
  - o Carry out an annual review of the strategy and report on progress and issues to the PCP
  - o One or more consumers/carers/community members to be nominated from the Workgroup to participate in the development of the PCP self-assessment tool
- ?? To build on relationships and mechanisms for consumer and community participation that already exist.
  - o Consumers and carers are a key stakeholder in the asthma integrated disease management project
  - o Identify components of best practice in consumer and community participation and include in training programs
  - o Develop effective working relationships with statewide agencies to build on their expertise, information and links with consumers in relation to particular health and well being issues
- ?? To encourage the active involvement of consumers in accreditation and quality improvement initiatives of the PCP

### 5.4 Training and Support

- ?? To provide consumers, carers and community members with training and support to assist their active participation in primary care
  - o Provide an appropriate orientation for consumers, carers and individual community members to the PCP and its specific committees
  - o Nominate PCP representatives to act as mentors and provide support to consumers or carers to facilitate their involvement in PCP activities
  - o Provide reimbursement of out-of-pocket expenses for consumer representatives on Committees
  - o Provide consumers and carers with appropriate orientation and training to enable them to be involved in state-wide planning and service development activities
  - o Provide support (eg. access to a computer and work area, access to photocopying etc) to consumer self help and support activities
- ?? To develop an awareness and training program for primary care service providers to support the development meaningful consumer/carer/community participation.
  - o Use the Asthma Integrated Disease Management project to develop an in-depth analysis of consumer participation and shared care
  - o Identify and build-on existing good practice
  - o Develop a planning tool to support effective participation

**Southern Grampians & Glenelg Primary Care Partnership**  
**PCP-GP Engagement and Communication Strategy**

**Vision:**

The creation of effective links between general practice and the broader primary care system.

**Endorsed: *date***

**1. SUMMARY**

General Practitioners are frequently the first point of contact with the primary care system and are therefore critical to the success of the Better Access to Services strategy. They are local and accessible and can play a key role in providing services, information and referral to people requiring a broad range of primary care services.

General Practitioners provide an interface between the acute, residential and primary care sectors and have an important role to play in health promotion, disease management and integrated service planning.

The Divisions of General Practice are recognized as the key agency for advice and consultation regarding the role and views of General Practitioners in relation to primary care services.

This document outlines the strategic and operational plan to encourage and support the involvement of General Practitioners in the implementation of the primary care reforms. It should be read in conjunction with the Southern Grampians & Glenelg Primary Care Partnership Community Health Plan.

**2. VALUES**

The Southern Grampians & Glenelg Primary Care Partnership is committed to:

- ?? actively pursuing primary care reform through partnership with General Practitioners
- ?? drawing on the expertise of General Practitioners in enhancing service delivery and developing consistent assessment and information management processes
- ?? identifying and overcoming barriers to General Practitioner participation
- ?? providing adequate resources to ensure service provider participation can be valuable, meaningful and effective
- ?? developing innovative means to involve General Practitioners in the work of the Partnership
- ?? building and supporting a good relationship between general practice and other primary care services

**3. GOALS**

- ?? Engagement of the PCP with the Otway Division of General Practice and General Practitioners in the development and implementation of joint projects to improve access to a coordinated service system

- ?? Strategies to increase General Practitioner's use of the Enhanced Primary Care benefits within a coordinated primary care network
- ?? Identification of local and general barriers to GP engagement with the primary care sector and development of strategies to improve the relationship

#### 4. KEY OBJECTIVES

##### 4.1 Communication

- ?? To provide accessible information to General Practitioners on primary care services
- ?? To develop and implement effective communication processes between General Practitioners, the Otway Division of General Practice and the Primary Care Partnership
- ?? Develop protocols between GPs and other primary care services around assessment, care planning and case conferencing

##### 4.2 Accountability

- ?? To develop clear and transparent guidelines for the involvement of Division of General Practice staff and General Practitioners in the work of the Primary Care Partnership
- ?? To sub-contract staff of the Otway Division of General Practice and/or General Practitioners in accordance with the Provider Participation Strategy

##### 4.3 Planning, Quality Improvement & Evaluation

- ?? To encourage the active involvement of General Practitioners in policy development, strategic planning and implementation of projects and policies
- ?? Develop strategies and joint projects for use of the MBS Enhanced Primary Care items relating to case conferencing and care planning
- ?? Link the PCP Integrated Service Plan with the Otway Division strategic plan to build a coordinated approach to planning

##### 4.4 Training and Support

- ?? To inform General Practitioners on the Primary Care Partnership and the reform strategies
- ?? To contract General Practitioners and/or staff of the Otway Division of General Practice for the implementation of specific projects.
- ?? Provide information and training to GPs about DHS proposed Initial Needs Identification and Care Planning tools and potential use by general Practitioners
- ?? Develop GP/consumer presentation(s) illustrating successful consumer involvement and shared care

## 5. OPERATIONAL PLAN

### 5.1 Communication

- ?? To provide accessible information to General Practitioners on primary care services
  - ?? Develop educational and display materials relevant to GPs (Powerpoint presentation, overheads and written)
  - ?? Provide easier access to information, though coordination of the local primary care services directory, about the range of appropriate services available and link this with statewide information
  - ?? To develop a common understanding of terms used within the primary care context
  - ?? To increase the distribution of the PCP Bulletin to interested General Practitioners
  - ?? Provide relevant and comprehensive information on services, contact and assessment processes, waiting lists and eligibility criteria
- ?? To develop and implement effective communication processes between General Practitioners, the Otway Division of General Practice and the Primary Care Partnership
  - ?? Encourage the Otway Division to continue as an active member of the PCP and the Executive Committee
  - ?? To implement the Information Management Strategic Plan to facilitate communication between General Practitioners and other primary care providers
  - ?? Evaluate the pilot use of the Initial Needs Identification and Care Planning tools from a GP perspective to identify how improved client information management can support better coordination of care
  - ?? The Otway Division of General Practice to foster communication between GPs, other primary care providers and the wider health system
  - ?? The Otway Division to contribute their knowledge and experience to assist the Partnership in the development of their information management strategy with respect to electronic communication tools for referral of patients, communication and joint care planning.
  - ?? The Community Participation Workgroup to develop strategies for consumer participation and input which will help to ensure that the GP strategy focuses on consumer based improvements and outcomes
- ?? Develop communication processes between GPs and other primary care services around assessment, care planning and case conferencing
  - ?? Consult GPs through the Otway Division on appropriate strategies to pilot the BATS and Information Management projects
  - ?? Survey GP issues in relation to:

- o Use of a single referral form for primary care services
- o Use of electronic referral
- o Requirements for feedback and involvement in case management
- o Building on MBS Extended Primary Care items for assessment, care planning and case conferences
- ?? Build on existing good practice in shared care
  - o I identify good practice and models within the catchment of GP and other primary care service
- ?? Otway Division to facilitate access to information and GPs

## 5.2 Accountability

- ?? To develop clear and transparent guidelines for the involvement of Division of General Practice and General Practitioners in the work of the Primary Care Partnership.
  - ?? Develop a GP Participation Reference Group to implement this strategy
  - ?? Define clear roles and responsibilities for general practice representation on other PCP steering groups and working parties
  - ?? Otway Division and/or General Practitioner representation on the Service Coordination Workgroup
  - ?? Review the GP integration strategy on a regular basis to take into account the changing needs of GPs, Divisions and other primary care providers
  - ?? Liaise and work with other Primary Care Partnerships within the boundaries of the Otway Division of General Practice to ensure the development of consistent practices
  - ?? Participate in developing a shared understanding of the issues involved in developing a collaborative approach
- ?? To sub-contract staff of the Otway Division of General Practice and/or General Practitioners in accordance with the Provider Participation Strategy
  - ?? I identify project work to support General Practitioner integration
  - ?? Develop professional service agreements to support General Practitioner project work
  - ?? Recruit interested General Practitioners to participate in PCP project work
  - ?? I identify alternative forms of recognition (such as media exposure and public acknowledgement) acceptable to General Practitioners

## 5.3 Planning, Quality Improvement & Evaluation

- ?? To encourage the active involvement of General Practitioners in policy development, strategic planning and implementation of projects and policies

- ?? Involve GPs in development and implementation of the asthma integrated disease management project to promote 'ownership' and commitment.
- ?? To ensure service information is accessible and meets the needs of general practice.
- ?? Improve coordination between the health promotion efforts of GPs and Divisions with those of other primary care providers
  - o Men's health/physical activity project
- ?? Develop the BATS framework in consultation with and to deliver tangible benefits to GPs and their patients
  - o Asthma Integrated Disease Management
  - o Diabetes retinopathy Screening
  - o Respite Care Coordination
  - o Improved Access to Counselling
  - o Primary Mental Health Team
- ?? The Otway Division to address population health through their Strategic and Business Plan and support GPs in their health promotion role in collaboration with the PCP
- ?? Otway Division to use the More Allied Health services program to provide additional allied health services in an integrated approach with existing providers.
- ?? Develop strategies and joint projects for use of the MBS Enhanced Primary Care items relating to case conferencing and care planning
  - ?? Provide project support to the Otway Division of General Practice to increase use of the MBS items for multidisciplinary case conferencing and care planning
  - ?? Use the Asthma Integrated Disease Management project and GP involvement to demonstrate the use of the MBS items
    - o The Otway Division to encourage GPs to participate in this Asthma IDM and use the MBS items to improve coordination of care for people with asthma
- ?? Link the PCP Integrated Service Plan with the Otway Division strategic plan to build a coordinated approach to planning

#### 5.4 Training and Support

- ?? To inform General Practitioners on the Primary Care Partnership and the reform strategies
  - ?? Develop educational and display materials relevant to GPs (Powerpoint presentation, overheads and written)
  - ?? PCP staff to be available to attend medical practices to provide updates on PCP activities, including specific project reports

- ?? Otway Division to facilitate access to GP educational sessions and practice meetings
- ?? To contract General Practitioners and/or staff of the Otway Division of General Practice for the implementation of specific projects.
  - ?? Apply the guidelines within the Provider Participation Strategy for the use of PCP funding to support the engagement of GPs in the work of the PCP
    - o Recruit a GP to participate in the men's health/physical activity health promotion program
    - o Recruit a GP project worker to coordinate GP engagement within the service coordination strategy
  - ?? DHS to seek funding to support the participation of GPs and other primary care practitioners in workshops on utilising the Enhanced Primary Care MBS items
  - ?? Use funded projects as a model for the improved integration of GPs within the primary care system and use of the MBS items for case conferencing and care planning
    - o Asthma Integrated Disease Management
    - o Diabetes retinopathy Screening
    - o Respite Care Coordination
    - o Improved Access to Counselling
    - o Primary Mental Health team
  - ?? Ensure the development of tangible benefits that can benefit both GPs and their practices as an incentive to adopt change
  - ?? Otway Division to investigate the use of Practice Incentives Program funding to remunerate General practitioners for quality activities related to Primary Care Partnerships
- ?? Provide information and training to GPs about DHS proposed Initial Needs Identification and Care Planning tools and potential use by general Practitioners
- ?? Develop GP/consumer presentation(s) illustrating successful consumer involvement and shared care
  - ?? Identify suitable case studies and interested consumers
  - ?? Liaise with Otway Division to ensure appropriate development of presentation material

## Southern Grampians and Glenelg Primary Care Partnership

### SERVICE COORDINATION - BETTER ACCESS TO SERVICES

2001 - 2002

#### GOALS

- ?? To develop terms of Reference for the PCP Service Coordination Implementation Management Group
- ?? To monitor how consumers access the primary care service system and receive information
- ?? To work with DHS to develop and pilot an effective Initial Needs Identification tool that is used by primary care providers together with consumers to ensure they receive appropriate services
- ?? To work with DHS to develop and pilot an effective Care Planning tool that facilitates the partnership between consumers and carers with primary care service providers to ensure needs, options and strategies are developed and implemented
- ?? To identify the range of service specific (including General Practitioners) and specialist providers and ensure their linkages within a coordinated primary care sector
- ?? To improve identification of consumers with complex or long term needs and improved processes for comprehensive assessment

#### OPERATIONAL PLAN 2001-2002

##### ***Initial Contact***

Initial contact is the point at which the consumer has first contact with the primary care service system.

- 1 Identify the existing situation in the primary care system
  - a Continue mapping existing capacity (due July 2001) throughout primary care service system (see [2.1a](#))
  - b Identify existing protocols, referral processes and sources (workshops)
  - c Identify best practice models from mapping process
  - d 6 month survey of Initial Contact activity across all primary care and community agencies (draft form attached [2.1c](#)) July - December 2001
  - e Identify opportunities to integrate access to health promotion activities at initial contact (workshops)
  - f Promote service database/directories to providers (see [2.3A](#))
  - g Consumer feedback process developed and implemented to identify consumer issues and ideas (see Community Participation Strategy [1.1C](#))

- 2 Map related sectors and overlaps with primary care system
  - a Complete mapping of community care system in Southern Grampians and Glenelg shires (Community Connections project - see [3.1c](#))
  - b Complete project identifying access issues for people with disability (due September 2001 - see [3.1R](#))
  - c Work with pharmacists through the Asthma Integrated Disease Management project to identify specific initial contact issues and referral processes ([3.3M](#))
  - d Identify issues relating to mental health through development of the Primary Mental Health Team ([1.3a](#)) and the Improved Access to Counselling project ([3.3O](#))
  - e Analyse and identify issues relevant to primary care services
- 3 Learn from existing projects
  - a Review of Southern Grampians Trauma support team (July 2001) initial contact process - methodology to be developed
  - b Analysis of best practice models identified in 1c above
  - c Identify barriers and enablers, issues relating to initial contact
  - d Work with GP practices (see [1.2A](#)) to develop integration strategies (see proposal [2.1i](#))
- 4 Develop implementation strategy to improve initial access to coordinated primary care system
  - a Prepare discussion paper collating evidence and consult broadly
  - b Develop consensus on protocols and forms for access, referral, consent (see proposal [2.2i](#))
  - c Identify options for development of service information database (see [proposal [2.3ii](#)]) and linking transport resources with the database (see proposal [2.3iii](#))
  - d Link with Information Management strategy via SW Vic PCP Steering Committee ([2.2c](#))
  - e Develop standards, competencies for best practice
  - f Identify gaps and issues for small agencies (eg no reception staff) and develop innovative solutions in collaboration with consumers
  - g Develop information and skills training programs for initial contact staff and volunteers
  - h Monitoring and evaluation plan developed
- 5 Develop future actions required
  - a Monitor implementation of agreed protocols
  - b Identify ongoing issues/problem solving
  - c Identify privacy and consent issues in collaboration with consumers and providers ([2.2i](#))

- d Identify duty of care issues especially around volunteers and non-professional staff; supervision and support needs
- e Promotion of functionally integrated primary care system to community

### ***Initial Needs Identification pilots***

Initial Needs Identification is not a diagnostic process but a screening for risk and service requirements

- 1 Identify the existing situation in primary care system
  - a Continue mapping existing capacity (due July 2001) throughout primary care service system (2.1a)
  - b Identify existing protocols, referral processes and initial assessment processes
  - c Identify best practice models from mapping process
  - d 6 month survey of initial contact activity (draft form attached 2.1c) due December 2001 to map actual transfer needs identification and referral processes
  - e Consumer feedback process developed and implemented to identify consumer issues and ideas
- 2 Learn from existing projects
  - a Sub-regional Coordinated Care Pathways project
    - ? ? Risk Screening and Risk Assessment tool is now used for all admissions to acute services; define overlaps and differences to manage overlaps as many service providers are involved in both acute and primary care sectors
    - ? ? Integration with other programs including Post Acute Care, Maternity Services Enhancement Program, Effective Discharge Planning Strategy and the Primary Care Partnership.
    - ? ? Development of key data collection requirements and software to support Sub Regional Coordinated Care Pathways Program; ensure consistent processes through SWARH management of information management process (2.2c)
  - b Analysis of projects and other best practice models identified in 1c above for lessons relating to initial needs identification
  - c Identify barriers and enablers, issues relating to initial needs identification
- 3 Preliminary pilot of draft Initial Needs Identification tool developed by DHS
  - a Convene provider workshops with DHS to contribute to development of the INI tool
  - b 3 month pilot of draft tool in volunteer agencies (Portland & District Community Health Centre, Western District health Service - Community Services, Community Connections and Glenelg shire)
  - c Pilot INI tool in the Improved Access to Counselling project (3.30) - access to brokerage funding

- d Evaluation of issues, problem solving, resource issues (workshops)
  - e Identify required staff competencies based on experience from the preliminary pilot
  - f Consumer evaluation of INI process and feedback
  - g Review cultural diversity implications
  - h Feedback to DHS and modification of Initial Needs Identification tool if required
  - i Identify additional local information requirements (to be further developed 2002/3)
- 4 Develop implementation strategy for introduction of Initial Needs Identification tool to all primary care agencies in catchment
- a Prepare discussion paper collating information from the preliminary pilot of the INI tool and use for consultation with agencies
  - b Identify agency capabilities to provide initial needs identification (from BATS survey [2.1a](#))
  - c Develop consensus on use of INI tool, protocols and forms for access, referral, consent
  - d Evaluate provider requirements of the service database (see Project [2.3i](#)) for referral
  - e Work with GP practices to identify issues pertinent to introduction of the INI tool in this arena through Otway Division of General Practice (see proposal [2.1i](#))
  - f Link with Information Management strategy via SW Vic PCP Steering Committee for management of client registration, transfer of information
  - g Develop quality standards, competencies for best practice
  - h Develop information and skills training programs for intake staff and a broad range of professional service providers
  - i Monitoring and evaluation plan developed; risk management strategies; consumer participation
- 5 Develop future actions required
- a Change management strategy developed; information, problem solving and support service to be provided by PCP project workers
  - b Monitor use of agreed Initial Needs Identification tool within primary care agencies
  - c Identify ongoing issues/problem solving
  - d Identify privacy and consent issues in collaboration with consumers
  - e Identify duty of care issues and referral/feedback processes between providers

- f Promotion of coordinated access and needs identification to broad service system and community
- g Links between initial needs identification and access to health promotion initiatives (see [3.2i](#))

### **Care Planning pilots**

Care planning includes the development of service plans, coordination and case management processes and referral and feedback processes for co-operative arrangements in the management of more complex care needs.

- 1 Identify the existing situation in the primary care system
  - a Continue mapping existing capacity (due July 2001) throughout primary care service system ([2.1a](#))
  - b Identify existing protocols, referral processes and information management
  - c Identify gaps and issues in care planning in primary care sector
  - d Identify existing best practice models
  - e Identify consumer participation strategies currently used in care planning (workshops follow up to BATS survey [2.1a](#))
- 2 Learn from existing projects
  - a Sub-regional Coordinated Care Pathways project coordinated through Western District health Service
  - b Analysis of projects and other best practice models identified in 1d above for lessons relating to care planning
  - c Provider workshops and focus groups to brainstorm issues; specialist and service specific; links with community care and disability sectors; consumer involvement
  - d Identify barriers and enablers, issues relating to care planning
- 3 Preliminary pilot of draft Care Planning tool developed by DHS
  - a Identify provider "volunteers" to carry out preliminary pilot; range of service specific and specialist services
  - b Work with general practitioners (see [1.2A](#)) to increase use of case conferencing and care planning Extended Primary Care MBS items (see proposal [2.1i](#))
  - c Pilot use of draft care planning tool in Asthma IDM project ([3.3M](#))
  - d Pilot use of draft care planning tool in Improved Access to Counselling project for consumers receiving brokerage funding for specialist counselling services ([3.3O](#))
  - e Evaluation of issues, problem solving, resource issues
  - f Identify required skills and resources based on experience from the preliminary pilot
  - g Feedback to DHS and modification of Care Planning tool if required
  - h Identification of additional local information required

- i Identify required communication and documentation systems
- 4 Develop implementation strategy for introduction of Care Planning tool to primary care agencies
    - a Prepare discussion paper collating information from the preliminary pilot of the care planning tool and use for consultation with broad range of providers
    - b Develop consensus on use of care planning tool, protocols and forms for access, referral, consent
    - c Work with GP practices to identify issues pertinent to introduction of the care planning tool and use of MBS items (see [2.1i](#))
    - d Link with Information Management strategy via SW Vic PCP Steering Committee for management of client information, coordinated appointments ([2.2c](#))
    - e Develop preliminary quality standards, competencies for best practice based on experience of coordinated care project
    - f Develop information and skills training programs for intake staff and a broad range of professional service providers
    - g Monitoring and evaluation plan developed; risk management strategies; consumer participation
  - 5 Develop future actions required
    - a Change management strategy developed; information, problem solving and support service to be provided by PCP project workers
    - b Monitor use of agreed care planning tool by providers
    - c Identify ongoing issues/problem solving
    - d Identify privacy and consent issues in collaboration with consumers
    - e Integration of health promotion programs into care planning

***Comprehensive Assessment (for PCPs conducting Integrated Disease Management Pilots)***

Comprehensive assessment incorporates an advanced level of assessment including physical, social, psychological and environmental factors from a range of sources where consumers have multiple, complex or unclear needs or chronic problems requiring long term service provision

- 1 Develop comprehensive assessment tool within Asthma Integrated Disease Management program ([3.3M](#))
  - a Currently mapping existing services, existing protocols, referral processes and information management
  - b Identify existing best practice models in asthma assessment
  - c Identify consumer participation strategies to be used

- 2 Cross-sectoral assessment processes and linkages
  - a Sub-regional Coordinated Care Pathways project - acute sector
  - b Work with disability agencies and Rural Access Workers to develop protocols for comprehensive assessment across the disability and primary care sectors
  - c Build on the Community Care project ([3.1c](#)) to identify comprehensive assessment issues across the sectors
- 3 Improve access of consumers with complex needs to comprehensive assessment
  - a Provider workshops and focus groups to brainstorm issues; specialist and service specific; links with community care and disability sectors; consumer involvement
  - b Preliminary ideas on risk assessment, potential protocols and processes
  - c I identify barriers and enablers, issues relating to comprehensive assessment
- 4 Develop future actions required
  - a Change management strategies to be developed; information, problem solving and support service to be provided by PCP project workers
  - b I identify privacy and consent issues in collaboration with consumers

#### ***Service Specific Assessment***

Service specific assessments are carried out by providers when consumers have a relatively obvious and distinct need

- 1 Identify service providers and assessment processes
  - a Use service database and service profile to identify providers and current assessment processes
  - b I identify innovative and existing best practice models in service specific assessment
  - c I identify linkages with initial needs identification, referral, comprehensive assessment and care planning processes
  - d I identify consumer participation strategies currently used
- 2 Develop the service database
  - a Ensure comprehensive information is collected to meet needs of referrers (see [2.3i](#))

#### ***Specialist Assessment***

Specialist assessments are carried out where the presenting need requires a specialist service response

- 1 Identify specialist services available within the catchment
  - a Use service database and service profile to identify providers and current referral requirements, assessment processes, eligibility, waiting lists

- b Identify innovative and existing best practice models in service specific assessment
  - c Identify linkages with initial needs identification, referral, comprehensive assessment and care planning processes
  - d Identify consumer participation strategies currently used
- 2 Develop service linkage strategies
- a Awareness and education of primary care providers of role of specialist services
  - b Develop Service Linkage Protocols with specialist agencies not signatories to the Joint Venture Agreement to define roles and responsibilities

***Proposed Budget for Implementation of the Better Access to Services Strategy 2001/2***

Expense	\$
0.5 EFT BATS Project Coordinator	30,000
Administration 200 hours x \$25.00 per hour	5,000
Backfill - agency staff time for piloting INI and CP tools, education (4 sites x \$6,000)	24,000
Workshops	1,000
Travel	2,000
Operating costs	5,000
Education and training sessions	8,000
<b>TOTAL</b>	<b>75,000</b>

Implementation of the BATS strategy in 2001/2002 will be supported by core funding for 2001/2 and roll-over funding from 2000/1. Additional projects have been developed and are summarized in Section 2.4 of the Community Health Plan.

**Southern Grampians and Glenelg Primary Care Partnership**  
**SERVICE COORDINATION - INFORMATION MANAGEMENT 2001/2002**

**GOALS**

The overall goals of the 5-year Service Coordination Information Management Strategy are listed below. The primary goals of the next year are identified in bold font:

- ?? To achieve functional integration of services so that the consumer experiences a seamless and integrated response
- ?? To develop information management processes that provide a base for improvements in the health and well being of the community:
- ?? **Establishing an information management environment that supports the communication of information among all primary care providers and consumers across the State**
- ?? **Developing new processes, building skills, and changing work practices in the primary care sector to build improvements in quality, accessibility, efficiency and health outcomes**
- ?? **To define common business processes, using the BATS framework, based on common standards and practices rather than common IT systems**
- ?? **To establish consumer confidence in the privacy and confidentiality of their information**
- ?? Efficiency gains through the appropriate use of information technology to allow providers to deliver improved services to consumers
- ?? To establish information management systems that deliver better service data to support integrated service planning.

**OPERATIONAL PLAN 2001/2002**

Priority tasks are indicated in bold type.

- 1 Establish a broad base of information management capacity and skills in the Primary Care Partnership.
  - a **Establish an effective governance mechanism to support the development of Information Management processes including:**
    - o Maintain the SWVPCP Steering Committee ([2.2c](#)) as the coordinating body to manage implementation of an agreed Information management strategy
    - o Agree SWARH membership fees established for primary care agencies
    - o To review the Terms of Reference for the Client and Administrative services sub-committees to reflect the Better Access to Services coordination model
    - o Form working groups to manage specific projects ([2.2c](#)) with defined reporting mechanisms to the Client or Administrative services sub-committees

- Develop appropriate processes for consumer representation on the sub-committees
  - b Establish a functionally integrated approach to Information Management that can be supported by a common IT infrastructure including:**
    - Develop an agreed Information Management Strategy for SW Victoria (based on the SWARHnet catchment area) to support the functional integration of primary care agencies and the provision of coordinated services to the community
    - Review the business process mapping carried out in 1999 (SWARH [2.2a](#)) to update information on the interaction within the local service system to support identification of the information requirements
    - Review the ePHACS Strategic Plan ([2.2a](#)) to ensure it continues to meet the needs of primary care agencies in developing a common infrastructure for information technology
    - Develop funding proposals through the SWVPCP Steering Committee to implement the updated strategic plan for information technology to ensure primary care providers have appropriate technology, professional support and education to carry out their work
- 2 Develop information management practices, protocols, processes and systems to support
- a Individual providers in their professional decision making processes
    - **Develop consistent work practices and protocols for obtaining informed consent (see [2.2i](#)) for Initial Contact and Initial Needs identification**
    - **Education and training for non-professional and professional workers on privacy legislation and obtaining informed consent**
    - **Develop a standard form for referral based on the Initial Needs Identification template between primary care providers that can be used by email, fax or for verbal referral**
  - b The sharing of health and care information relating to individual consumers
    - **Pilot draft Care Planning tool (see [2.1A](#)) and identify issues for providers and consumers on information sharing**
    - **Develop a workgroup of primary care providers to report to the Client Services sub-committee of SWVPCP and make recommendations to inform policies on sharing consumer information**
    - The SWVic PCP will receive recommendations from work groups and DHS to inform the development of a consistent policy across SW Victoria on sharing of information. See the draft SWARH proposal ([2.2b](#))
    - SWVPCP sub-committees to develop policies and protocols for collection, management of and access to data for each stage of the BATS model
    - Initiate consultation on the development of a single client record number between primary care agencies

- **Liaise with similar programs in the acute sector such as the Coordinated Care Pathways program; develop consistent processes and practice**
- **Use the asthma integrated disease management project to develop information management processes including consumer education and participation and the full range of providers (3.3M)**
- c The sharing of services information to assist consumer entry and navigation and provider navigation, referral and coordination
  - **Develop the service database (see 2.3i, 2.3iii) to support access and navigation**
  - **Develop policies and protocols on access to local information (see 2.3i) for consumers and providers**
  - Workgroup to develop Recommendations on linking service information for SW Victoria with client data
- d The provision of reference information, including health prevention and promotion information, for use by providers and consumers and their carers
  - **Increase awareness of health promotion across the primary care workforce through participation in current training opportunities**
  - **Workshop providers including GPs on education information currently being used for health promotion with clients; identify issues in developing/accessing standardized resources**
  - **Increase awareness and confidence in using the Better Health Channel as a source of health information**
- e Planning and management capacity, including financial management and the aggregation of data to contribute to integrated service planning
  - **Survey primary care agencies on current data collection and reporting requirements (see 2.1a)**
  - **Develop workgroup reporting to the SWVPCP Administrative Services sub-committee to develop recommendations on improved management of service utilization data**
  - **SWVPCP Administrative Services sub-committee to liaise with DHS and develop recommendation for policies and practice relating to management and reporting of service utilization data**
  - **Develop improved information management capacity, including the aggregation of information to contribute to integrated service planning (see proposal 2.3ii)**
- 3 Develop information management processes that provide a base for improvements in the health and well being of the community:
  - a Encourage healthier lifestyles and a reduction in risk factors by providing health and lifestyle information.
  - b Develop systems that enable compliance with advice given by providers, especially by using follow-up contacts

- o **See the asthma integrated disease management program (3.3M)**
  - c Support self-management of care, especially for people with chronic conditions
    - o **Develop standardized education materials within the asthma integrated disease management program (3.3M)**
  - d Encourage appropriate use of primary care and community services to reduce the need for acute health services
  - e Promotion of service availability and eligibility information to assist consumers and providers in decision making
    - o **Develop the service database (see 2.3j, 2.3iii) to support access and navigation**
  - f Effective coordination of care and information sharing
- 4 Work within the "whole of sector" approach to the development of information and communication technology infrastructure and capabilities within the sector.
  - a Work with key stakeholders, including consumers, acute and residential care sectors, disability and community care services within South West Victoria.
    - o **Identify referral and communication processes between community care agencies and identify the potential for integration into a single network (see 3.1c)**
    - o **Linkages with sub-acute Coordinated Care Pathway program (see 2.2f)**
  - b Involvement (partnership manager/information manager) with DHS activities to coordinate activities across the State.
  - c Work within the standard infrastructure and minimum data sets specified by the Department
    - o **Pilot the Initial Needs Identification and Care Planning tools**
  - d Conform with the Department's purchasing requirements for information and communications technology infrastructure investment.
    - o **SWARH to be aware of DHS purchasing requirements and make appropriate recommendations to the SWVPCP Steering Committee**
  - e Awareness of statewide coordination and integration with the national approach to health information management including common national and international standards
    - o **SWARH to monitor state and national approaches to health information management including common national and international standards and report to the SWVPCP Steering Committee**
- 5 Work with the Department of Human Services in the development and simplification of data collection and the reporting requirements for agencies
  - a Pilot the datasets for services information, initial needs identification and care planning within PCP agencies and develop consistent practices, processes and systems for information management

- b Pilot a framework for comprehensive assessment in the Integrated Disease Management projects in SW Victoria and develop consistent practices, processes and systems for information management
    - o **Map existing assessment processes in asthma management and identify key requirements for information management**
    - o **Establish an integrated disease management working group within the SWVPCP Steering Committee to make recommendations on work processes and protocols for sharing of consumer information, review and recall processes**
    - o Develop reference information to guide care and treatment decisions including support tools such as schedules and templates to assist practitioners
  - c Implement a common approach to the data reporting framework to be developed by Department of Human Services
  - d Inform the development of mechanisms for informed consumer consent to support the management and communication of personal information and to satisfy privacy legislation requirements
    - o **Identify provider and consumer issues with privacy and obtaining informed consent (proposal [2.2i](#)) and develop appropriate protocols**
  - e Develop understanding of the national guidelines for the secure management of health information and facilitate education sessions with primary care providers
- 6 Develop and implement projects and develop processes to address critical issues in information management including:
- a **The privacy and confidentiality of consumer information (proposal [2.2i](#))**
  - b Encourage primary care providers to use the Better Health Channel to inform their clients and patients about health and lifestyle matters
  - c **Ensure the service databases meet provider and consumer needs (proposal [2.3i](#))**
  - d **Improve access to transport information to improve access to services (proposal [2.3iii](#))**
  - e **Promote the Primary Health Knowledge Base and other resources to primary care providers through the PCP Bulletin**
  - f **Improve access to local information to support planning (proposal [2.3ii](#))**
  - g Develop effective project evaluation to maximize and share the learning

In addition to projects that have been developed and are summarized in Section 2.4 of the Community Health Plan, funding to support project work identified in the Information management Strategy for 2001/2 is sought.

***Proposed Budget for Implementation of the Information Management Strategy 2001/2***

Expense	\$
Project hours 1000 hours@\$35.00 per hour	35,000
Administration 200 hours x \$25.00 per hour	5,000
Workshops	1,000
Travel	2,000
Operating costs	5,000
Education and training sessions	2,000
<b>TOTAL</b>	<b>50,000</b>

Use of this funding would be negotiated with PCP-South West and SWARH to achieve consistent goals across South West Victoria.

## SERVICE INFORMATION STRATEGY

### Vision

Improved community access to services through effective information provision

**Endorsed: June 2001**

### 1. SUMMARY

In 2001, the Southern Grampians & Glenelg PCP will establish and maintain a local primary care service directory on behalf of all agencies in the district and will ensure this is compatible with DHS requirements for a state-wide database. The database will support the goals of the Information Management Strategic Plan in relation to the sharing of services information to assist consumer entry and navigation and provider navigation, referral and coordination.

Information contained within the local service directory will also support the implementation of the local *Better Access To Services* model and *Integrated Service Planning* model.

In 2001/2 the Partnership will negotiate and implement a coordinated approach to telecommunications that supports the provision of information about services to providers, consumer and carers at their first point of contact with the partnership.

Development of a 3 year local service information strategy will build on these initiatives.

### 2. VALUES

- ?? The service information process established by the PCP will not duplicate the work of or disadvantage any agency.
- ?? The PCP database will record information in a manner compatible with the requirements of a statewide database
- ?? Information about primary care services within the Southern Grampians and Glenelg shires will be collected according to the statewide data standards as identified by DHS
- ?? Service information will support initial contact and initial needs identification and care planning pilots.
- ?? The service information process will simplify the collection, maintenance, dissemination of and access to information for agencies and service providers.
- ?? The information will be credible, reliable, current and updated in a timely manner.

### 3. GOALS

- ?? To provide comprehensive information on services available to the community, provided by the PCP members and also on the other relevant health and community support services within the catchment, to strengthen co-ordination of the service system in the shires of Southern Grampians and Glenelg.
- ?? To ensure information is available to service providers and the community

## 4. KEY OBJECTIVES

### 4.1 Communication

- ?? To develop and maintain a service information database on services in the shires of Southern Grampians and Glenelg.
- ?? To develop and implement a coordinated approach to telecommunications that supports the provision of information about services to providers, consumer and carers at their first point of contact with the partnership.

### 4.2 Accountability

- ?? To form a Reference Group of interested service providers and key stakeholders from the PCP and community to overview the development of the PCP Service Directory.

### 4.3 Planning, Quality Improvement & Evaluation

- ?? To ensure the information in the service database is accessible and meets the requirements of both providers and consumers

### 4.4 Training and Support

- ?? Work through the SWARH SW Vic PCP Steering Committee to address the basic systemic issues of networking and increasing the availability of computer equipment and training for service providers to manage the successful transition to a fully networked information resource.

## 5. OPERATIONAL PLAN

### 5.1 Communication

- ?? To develop and maintain a service information database on services in the shires of Southern Grampians and Glenelg.

#### PCP Tasks

- o Purchase appropriate software to store service information
- o To incorporate existing databases (the Southern Grampians Health & Welfare Directory and Portland Services Directory) into the PCP database.
- o Identify priorities for management (including collection, sharing, use and updating) of services information within the partnership.
- o Ensure the database contains information about service types and their descriptions, location, hours of operation, eligibility criteria, priority of access guidelines, waiting times, etc. consistent with the guidelines developed by DHS
- o Provide information on primary care agencies to other local, specialist and statewide databases to ensure community access to comprehensive information.
- o Provide a service to agencies and service providers through the provision of individual personalised directories in formats appropriate to their needs.

## Agency Tasks

- Provide current information to the PCP for inclusion in the database as required
- ?? To develop and implement a coordinated approach to telecommunications that supports the provision of information about services to providers, consumer and carers at their first point of contact with the partnership.

## PCP Tasks

- To be addressed through the SWARH SW Vic PCP Steering Committee and implementation of the ePHACS strategic plan

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**5.2 Accountability**

- ?? To form a Reference Group of interested service providers and key stakeholders from the PCP and community to overview the development of the PCP Service Directory.

## PCP Tasks

- Convene the Reference Group with agreed Terms of Reference
- Provide administrative support and adequate resources

## Agency Tasks

- Encourage membership from their staff

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**5.3 Planning, Quality Improvement & Evaluation**

- ?? To ensure the information in the service database is accessible and meets the requirements of both providers and consumers

## PCP Tasks

- Consult with providers to improve the information content and accessibility ([2.3i](#)) in the database
- Develop regular protocols for the transfer of information to statewide directories
- Develop an information storage facility to improve information availability for health promotion and integrated service planning ([2.3ii](#))
- Pilot development of transport links within the services database ([2.3iii](#))

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**5.4 Training and Support**

- ?? To address the basic systemic issues of networking and increasing the availability of computer equipment and training for service providers to manage the successful transition to a fully networked information resource.

## PCP Tasks

- Membership of the SWARH SW Vic PCP Steering Committee
- Implementation of the ePHACS strategic plan

Agency Tasks

- Nominate representatives to the SWARH SW Vic PCP Steering Committee
- Contribute to the costs of connecting to the IT network

**INTEGRATED SERVICE PLANNING STRATEGY****June 2001 - 2004****Vision**

**To build an enduring planning process integrating population health and well being into primary care planning and service delivery**

**Endorsed:****1. SUMMARY**

The Integrated Service Plan will provide a common understanding of both the general and various local needs within the catchment area and will direct the future work of the PCP.

It will build population health and well being into primary care planning and service delivery and to enable services to respond in a coordinated and targeted fashion with better outcomes for the community.

Planning will be developed as an enduring process making efficient use of information and resources. It will inform both DHS and individual agencies of the agreed priorities.

**2. GOALS**

- ?? To establish service planning as a continuous and sustainable process
- ?? To integrate the social model of health as the basis for planning that includes health promotion, treatment, community support and chronic disease management
- ?? To ensure service planning is based on identified community needs and information collected in an efficient and strategic manner
- ?? To ensure the involvement of consumers, carers and the general community in the planning process is built in to a sustainable process.
- ?? To facilitate collaborative and coordinated action by primary care providers in the implementation of agreed priorities.
- ?? To ensure the integrated primary care service plan will build on and contribute to, rather than duplicate, related planning processes in the region.

**3. KEY OBJECTIVES**

- 3.1 Communication
  - ?? To provide information to providers to support their active participation in planning
- 3.2 Accountability
  - ?? To develop clear and transparent guidelines for management of the planning process and decision-making
- 3.3 Planning, Quality Improvement & Evaluation
  - ?? To identify local variations and priorities to inform integrated service planning

- ?? Promote a coordinated approach to planning in collaboration with other levels of government and alliances
  - ?? Development of collaborative strategies and the active involvement of primary care providers to address agreed priority community needs.
- 3.4 Training and Support
- ?? Provide an information and resource service to primary care providers
  - ?? To develop the workforce capacity to engage in service planning
  - ?? To provide the community with training and support to assist their active participation in primary care planning

## 4. OPERATIONAL PLAN

### 4.1 Communication

- ?? To provide information to providers and the community to support their active participation in planning
  - o Use the PCP Bulletin to disseminate information to providers
  - o Provide feedback to providers and community on strategies developing from the planning process and the outcomes from implementation
  - o Develop terms of reference for planning work groups as required
  - o Establish a PCP intranet to support the work of groups and facilitate broad involvement of providers and the community in discussion
  - o Develop strategies for the ongoing collection, storage and dissemination of community and service data relevant to planning
  - o Develop an "information bank" of information and data to inform future planning

### 4.2 Accountability

- ?? To develop clear and transparent guidelines for management of the planning process and decision-making
  - o Terms of reference for a PCP Planning Coordination group to be developed
  - o Agree expectations and responsibilities of individual agencies within collaborative planning and implementation processes to be agreed
  - o Build on the "Common Planning Protocol" (DHS and MAV) to develop PCP protocols for a coordinated approach to planning

### **4.3 Planning, Quality Improvement & Evaluation**

- ?? To identify local variations and priorities to inform integrated service planning
  - o Negotiation with Shire of Southern Grampians on release of the Social Development Plan for use by the PCP
  - o Distribution of the community profile (July 2001) to agencies and community groups
  - o Consultation and feedback from agencies, consumers and other stakeholders in a variety of ways (October 2001)
  - o Preparation of a comprehensive community profile based on feedback (November 2001)
  - o Endorsement of the completed profile (December 2001) and identified priorities as the basis of future collaborative planning
- ?? Promote a coordinated approach to planning in collaboration with other organisations, levels of government and alliances
  - o Develop protocols for exchange of information between related planning activities
  - o Development of common information management strategies for sustainable planning processes
  - o Develop an "information bank" of information and data to inform future planning (see proposal [2.3ii](#))
  - o Develop effective working relationships with statewide agencies to build on their expertise, information and links with consumers in relation to particular health and well being issues
- ?? Development of collaborative strategies to address agreed priority community needs.
  - o Development of agreed decision making guidelines including potential impact on health and well being, ability to make a realistic difference and community support.
  - o Development and testing of a common planning framework to guide the development of projects
  - o Agreed guidelines for decision making on lead agencies and involvement of all PCP agencies in ongoing management and decision-making
  - o Evaluation processes agreed and built in to the PCP self-assessment framework

#### 4.4 Training and Support

- ?? Provide an information and resource service to primary care providers
  - o Distribute the community and service profiles widely throughout the agencies and community
  - o Provide access to additional detailed data for individuals and groups on request
  - o Improve provider access to policy, guidelines and other relevant documents produced by DHS, the PCP and other relevant organisations in hard copy and electronic formats
- ?? To develop the workforce capacity to engage in service planning
  - o Publicise training opportunities that will support planning through the PCP Bulletin
  - o Develop and disseminate resource materials to support local planning activities
  - o Identify provider training needs and develop strategies to build skills
  - o To develop primary care provider awareness and resources to support the development meaningful consumer/carer/community participation (see Community Participation Strategy [1.1C](#))
- ?? To provide the community with relevant resources to facilitate their meaningful involvement
  - o Develop plain English resource materials to inform consumers, carers and the public

## HEALTH PROMOTION STRATEGY

2001 - 2004

### Vision

Collaborative programs to address the social, environmental, biological and medical determinants of health will result in improvements in health and wellbeing for the population of Southern Grampians and Glenelg Shires

### Endorsed:

#### 1. SUMMARY

Development and implementation of an integrated health promotion program in 2001/2 will be used to develop consensus on process, management and evaluation in the future development of integrated health promotion programs by the PCP.

#### 2. VALUES

Health Promotion is "the process of enabling people to increase control over, and to improve, their health." Health is defined as "a complete state of physical, mental and social well being, not merely the absence of disease or infirmity" (World Health Organisation). Within the social model of health, improvements in health and wellbeing are achieved by directing efforts towards addressing the social and environmental determinants of health, alongside biological and medical factors.

This definition of health highlights the importance of understanding health and disease burden within the personal, social and cultural context specific to the person or community whose health is being considered. It is not possible to decide how best to support the improvement of health without understanding these factors. The Community Profile will be a major contribution to this understanding.

Primary care services will work through the Primary Care Partnership to take a collaborative role in addressing health promotion, which is regarded as an integral element of the work of all service providers.

The social model of health extends health promotion responsibility beyond those who would usually identify as health providers and there is already a well-developed group of workers with good connections across agencies and their communities who are actively supporting the development of integrated health promotion. The overall strategy being pursued is comprehensive, builds on existing work and will increase the skills and capacity of providers to contribute effectively.

Health promotion is an integral part of disease management, both in terms of prevention or delay of chronic illness in those at risk, and in terms of secondary prevention for people with identified chronic conditions. Health promotion and illness prevention activities will link directly with the asthma disease management program (3.3M) so that service providers target risk and protective factors associated with particular conditions, as well as the conditions themselves.

The Primary Care Partnership has a broad membership base involving most of the players with key responsibility for health promotion, who will inform and be informed by individual providers of health promotion. In achieving this, the sharing of experience and skills between services, education and effective linkages with regional and statewide sources of expertise and support is critical.

An integrated health promotion program is one that involves collaborative and coordinated effort between primary care providers. They are aimed at particular health and well-being issues which are of common significance to the community. An integrated health promotion system is one that incorporates coordinated action, consisting of an appropriate mix of approaches and interventions, across programs and sectors and involving a variety of providers and community groups, based on an agreed strategy. Integrated programs will frequently involve organisations beyond the primary care sector, such as schools, recreation clubs and commercial businesses.

### 3. GOALS

- ?? To build health promotion into all aspects of primary care planning, service delivery and evaluation to develop a sustainable and integrated health promotion system
- ?? To achieve consensus on the roles and responsibilities of the key stakeholders in health promotion
- ?? To define the key social determinants of health which need to be considered in the local context in developing health promotion programs;
- ?? To survey the range of health promotion programs that are available and how these can be better coordinated, integrated or improved
- ?? To develop a capacity building strategy for effective development of integrated health promotion
- ?? To agree a management model for the planning, implementation and evaluation of health promotion programs
- ?? To ensure comprehensive resources are available to providers to advance their understanding of health promotion and the development of programs.

### 4. OPERATIONAL PLAN

#### 4.1 Communication

- ?? Support communication between providers to support health promotion
  - o Include information on health promotion and PCP activities in the PCP Bulletin
  - o Encourage broad membership of the Health Promotion Reference Group
  - o Develop Service Linkage Protocols with specialist service providers in the area such as women's health and domestic violence
  - o Liaise with statewide health promotion organisations relevant to specific programs
  - o Participate in the development of protocols between DHS, PCPs and the Statewide/NGO Health Promotion Sector

- ?? Support consumer and community involvement in health promotion activities
  - o To provide relevant and understandable information to consumers, carers and the community to assist their active participation in planning and health promotion activities
  - o Consult with a broad range of community groups and consumers on the community profile as part of the priority setting process
  - o Develop protocols and templates to ensure effective consumer and carer participation in planning, management and evaluation of health promotion activities
  - o Develop evaluation criteria to measure consumer and community participation in health promotion programs
  - o Promote the results of health promotion programs to the community
  - o Refer Community Participation Strategy ([1.1C](#))

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#### **4.2 Accountability**

- ?? Develop management and governance structures that support health promotion principles and goals
  - o Develop a Health Promotion Reference Group, membership of which reflects the multidisciplinary approach to health promotion
  - o Build consumer and community participation into the management and development of health promotion activities
  - o Develop a clear set of roles and responsibilities for leadership and coordination of health promotion activities
  - o Develop decision making guidelines in terms of identifying key priorities for health promotion action, target groups and opportunities for interagency and intersectoral collaboration
  - o Review the health promotion strategy to take into account changing needs and the increasing capacity of providers to develop programs
  - o Agree guidelines for fund-holding and financial reporting for health promotion project funding
- ?? Identify expertise in health promotion in the catchment and how this can be accessed in developing and implementing health promotion strategies
  - o Map existing personnel and skills in health promotion, including best practice examples
  - o Collect examples of health promotion project templates and tools currently being used

- ?? Develop a budget for health promotion activities
  - o Identify current funding and spending by agencies on health promotion activities
  - o Identify the resources contributed to health promotion including staff, facilities and expertise
  - o Develop consensus on agency contributions to collaborative health promotion activities
  - o Develop collaborative proposals for health promotion funding

#### **4.3 Planning, Quality Improvement & Evaluation**

- ?? Develop a health promotion strategy and action plans that specify selected goals, objectives and interventions for health promotion outcomes
  - o Develop and implement a collaborative health promotion project in 2001/2 based on a priority activity (see Proposal [3.2i](#))
  - o Review evidence-based health promotion practice and identify core principles appropriate for rural health promotion
  - o Pilot and develop consensus on the components of an integrated health promotion program to be used by the PCP
  - o Evaluate the implementation of the agreed health promotion strategy to identify barriers and enablers to the future development of successful integrated health promotion programs across the catchment
- ?? Undertake data collection and gap analysis of current service use, based on health promotion planning and evaluation needs
  - o Use the community and service profiles to identify general and local priorities
  - o Link planning with the Municipal Health Plans to support an integrated approach to health and well being issues
  - o Link with other planning processes such as Drug and Alcohol strategies, mental health plans and Safety plans
  - o Work with the Otway Division of General Practice to support the use of evidence-based health promotion in general practice
- ?? Integrate health promotion within funded projects and develop linkages with other primary care providers
  - o Asthma Integrated Disease Management Program ([3.3M](#))
  - o Diabetes Retinopathy Screening ([3.3P](#))
  - o Primary Mental Health Team
  - o SW Community Transport Development ([3.1b](#))

#### 4.4 Training and Support

- ?? Create a health-promoting working environment
  - o Identify good practice and role models within the membership
  - o Identify criteria for effective leadership in creating health promoting environments
- ?? Increase the capacity of the total workforce to be involved in health promotion
  - o Review the skills of the workforce and structures within the organisation that support collaborative health promotion initiatives (DHS Training Needs Analysis 2)
  - o Establish the health promotion training needed to support integrated health promotion across the PCP
  - o Encourage providers to participate in the Core Health Promotion Short Course (5 day)
  - o Liaise with the DHS Regional Health Promotion Officer for assistance and advice
  - o Develop local training and education to meet the specific requirements for effective implementation of agreed health promotion activities
  - o Coordinate the collection of health promotion resources and ensure these are available to providers throughout the catchment
- ?? Ensure a health-promoting approach to client service delivery
  - o Review the principles of primary care service delivery to identify where health promotion can be integrated
  - o Encourage providers to integrate health promotion into daily client contacts, through planned and opportunistic interventions
  - o Include standards and criteria for health promotion activity in the quality improvement strategic plan and self-assessment tool to be developed
  - o Develop programs that empower and enable consumers to maintain and enhance their health status, rather than fostering dependence on services
  - o Apply the community participation strategy ([1.1C](#))