

Frankston Mornington Peninsula Primary Care Partnership

Community Health Plan 2006 - 2009

Deliverable 1: Partnership

December, 2006

Endorsed by PCP Chair:

Name: Christine Morka

Signature:



Date: 17/1/07

1. Partnership vision

What is the agreed vision for the PCP partnership for the period 2006–09?

By working together FMPPCP member agencies will be significantly improving the mental health and wellbeing of the community in Frankston City and Mornington Peninsula Shire.

The vision underpins the PCP's strategic priority of mental health and wellbeing (specific focus – family violence and social isolation):

- **partnerships** – supporting and strengthening new and existing partnerships across the range of PCP activities (e.g., health promotion, service coordination and chronic disease management), particularly with other sectors such as education, child and family and domestic violence services.
- **capacity building**
 - assisting community members to have a voice in relation to their health care, and
 - assisting innovation and supporting the network of primary care health professionals with training and development opportunities
- **facilitation and leadership** - by providing a mechanism for change, including assistance with strategic planning and partnership development.

2. Achieving the vision: *priority setting and problem definition*

Frankston Mornington Peninsula Community Profile

The FMP PCP comprises two local government municipalities, Frankston City and Mornington Peninsula Shire - referred to as the 'sub-region'. The sub-region comprises the City of Frankston, with a population of 113,967 residents in 2001, and the Mornington Peninsula Shire with a population of 138,088 residents in 2001. The sub-region is broadly characterised by a younger population in Frankston City and an older population in the Mornington Peninsula Shire, with a number of socio-economic issues impacting on the health and well-being of residents, including, early school leavers, low incomes, and smaller numbers of people with formal qualifications.

Social disadvantage resulting from socio-economic factors has been identified by the study *Unequal In Life: The distribution of social disadvantage in Victoria and New South Wales*. This report took nine indicators of social disadvantage and compared these across postcodes in NSW and Victoria.

The indicators were:

- | | |
|---------------------|---------------------------|
| 1. Mortality | 6. Child maltreatment |
| 2. Crime | 7. Childhood injuries |
| 3. Income | 8. Psychiatric admissions |
| 4. Education | 9. Emergency relief |
| 5. Low birth weight | |

The Frankston and Mornington Peninsula areas have four out of thirty postcodes with the highest disadvantage factors' scores. They are, Hastings, Frankston North, Rosebud West, and Rye.

It is suggested that these communities are more likely to have a reduced quality of life, particularly in relation to mental health and social connectedness¹.

Topography of the Mornington Peninsula is such that some communities are relatively isolated and there are significantly lower proportions of its population who do not speak English well or not at all compared with Melbourne. An indigenous community is also present and local government, and agencies continue their efforts in meeting the community's needs.

Frankston

The City of Frankston is situated on the eastern shore of Port Phillip, approximately 40 kilometres south of the Melbourne Central Business District (CBD). The municipality covers an area of approximately 131 square kilometres from Seaford Wetlands in the north, bordering Mount Eliza in the south and east to the Western Port Highway. The western boundary is formed by approximately 10 kilometres of Port Phillip coastline.

Frankston is a regional hub for retail, employment, cultural, professional and administrative services for Melbourne's south-eastern suburbs and the Mornington Peninsula. The Frankston Central Activities District (CAD) is one of the largest retail centres outside the Melbourne CBD.

Population growth in the municipality will be concentrated within the

¹ Tony Vinson, *Unequal in Life: the distribution of social disadvantage in Victoria and New South Wales*, The Ignatius Centre for social policy and research August 1999

Carrum Downs and Langwarrin districts, whereas established areas of Seaford and Frankston South may see some small decline. Frankston has a young population and most residents are Australian or British born. The socio-economic status of people living in Frankston is generally lower than that of the Melbourne².

Mornington Peninsula

The Shire of Mornington Peninsula is located between Port Phillip Bay and Western Port, approximately 50 Kilometres south-east of Melbourne.

The Shire has a total area of more than 720 square kilometres, with rural areas of above average productivity, scenic landscapes of State significance and a coastline extending for more than 90 kilometres. Substantial areas of the municipality, including the Western Port coast and the Mornington Peninsula National Park, are of high conservation value and support sites of national and international significance.

The Peninsula's settlement pattern consists of more than 20 townships, ranging from the relatively large centres of Mornington, Somerville Hastings, Dromana and Rosebud, through to small towns and coastal villages such as Red Hill, Flinders and Merricks Beach. This settlement pattern and the relationship between the townships, the coast and the rural place contribute to the Peninsula's distinctive 'sense of place'. The municipality's population significantly increases during peak summer time.

The Shire of Mornington Peninsula is not a designated urban growth area and the limitation of urban development on the Peninsula is consistent with State policy. However, within the established boundaries of townships on the Peninsula there are still substantial

² www.portofhastings.vic.gov.au/files Consultation Draft October 2006: Appendix G

areas set aside for further residential development. There is a spread of population across most age groups in the Shire. The residents of Mornington Peninsula are less culturally diverse and are of a lower socio-economic status as compared to the Melbourne.

The Political Context of Partnership Development

In September 2006, the Office for Public Policy at University of Melbourne ran an international conference on Governments and Communities in Partnership³. A number of interesting papers on the global move towards government/community partnerships and collaboration were presented. For example, M Grace presented a paper on the 'whole of government approaches' that we hear so much about in the Victorian Primary Care Partnership Strategy⁴. Grace neatly encapsulated the changing political environment when he said that the contemporary global environment includes a change in the way governments regard the nature of social problems and the correspondingly appropriate role of government in planning, funding and delivering services. Grace traces the international rise of neo-liberal ideas in the 1990's which saw social problems as the result of individual dysfunction and the (reduced) role of government was to fund clinical and therapeutic services rather than prevention and community development. The 1990's also saw the rise of government driven competitive tendering amongst service providers which produced a culture of competition and suspicion rather than one of collaboration and partnership.

Grace notes that these changes have had profound impacts on service delivery and outcomes. The critique of the impacts of neo-liberalism on social service delivery included a questioning of the

³ <http://www.public-policy.unimelb.edu.au/>

⁴ Dr Marty Grace 'Whole of government approaches and joined up services: a challenge to neo-liberalism?' School of Social Sciences, Victoria University Refereed paper presented to the Governments & Communities in Partnership: from theory to practice conference, 25-27 September 2006, Melbourne

'silo' arrangements for funding social programs. Strict managerialist governance resulted in funds flowing inflexibly from government to service delivery sites, with front-line workers frustrated by trying to fit real people and their unruly situations into tightly bureaucratically and administratively defined social programs.

Over the past few years challenges to the dominance of these neo-liberal philosophies have emerged, most dramatically as part of third way politics in Britain. In Australia, governments at federal, state and local levels are keenly interested in whole of government approaches, joined up services, cooperation, collaboration, participation, more democratic, and less managerialist approaches to both governance and service delivery." A presentation at the Governments & Communities in Partnership Conference showed why.

The presentation came from an in-house report and as the full report was not intended as a public document, the source remains confidential. The presentation notes the changing relationship between the community sector and Government in Victoria, with ever increasing reliance by Government on the community sector to deliver services. The community sector is sometimes called the "third sector", as opposed to the public and private sectors. The presentation examines one part of the sector, community sector organisations, (CSOs), but say that the findings can be applied more broadly (and it mentions the health sector in particular).

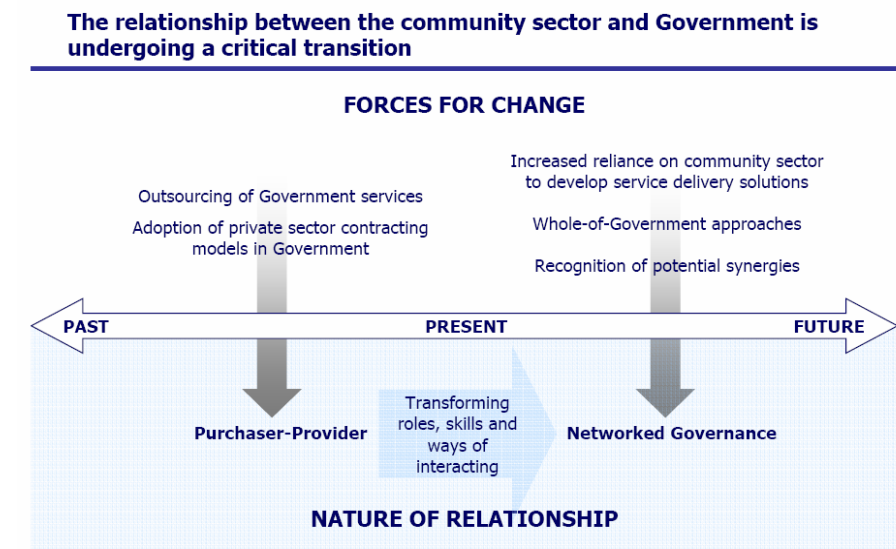
The community sector is an important economic and social force in Victoria. Consequently, the Victorian Government must put greater effort into improving the complex relationship it shares with the community sector to address challenges in Victoria's future.

There are many challenges in the Government's relationship with the community sector. Forecasts predict that the Government alone will have difficulty maintaining its current level of service delivery given Victoria's ageing population. The report identifies community

sector capacity as the linchpin of the community sector and Government's ability to jointly address this gap.

The presentation identifies that the community sector contributed over \$17 billion or nearly 3% to GDP in 1999-2000 including volunteer labour. It employs 351,000 people or nearly 4% of the national workforce. The community sector provides a wide range of community services, valuable community facilities, and is as well, a vehicle for the community to express their views. It provides opportunities for people to participate in community life

The following slide from the presentation shows the changing relationship between the community sector and Government, as well as its direction away from 'private sector contracting models' towards whole of government approaches to increased reliance on community sector networks and partnerships.

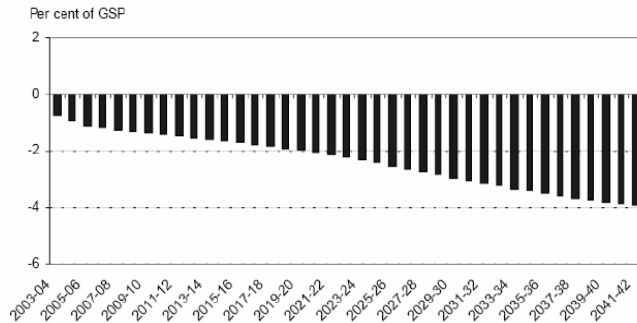


The following slide speaks for itself in terms of the reason why Government is relying more and more on the health and community sectors to deliver services.

Growth in demand is putting increasing pressure on the Government budget

Victoria faces considerable fiscal pressure over coming decades and the key driver is increasing health care expenses. By the year 2041, Victoria's fiscal gap¹ is forecast as reaching \$15 billion, if no policy changes are made.²

Projection of Victoria's fiscal gap^{1,2}



1. Fiscal gap is defined as the budget deficit once the effect of interest payments have been excluded
 2. DTF (2003), *Shaping a Prosperous Future*

The report points to capacity building and partnership development as the way to meet service needs.

Capacity underpins everything Government wants from the sector...

Government needs the sector to have the capacity to meet increasing service demand. Consultation with academics, Government and the community sector has revealed that service delivery is more strategic and efficient when:

- data is available to support decision-making and continuous improvement
- decisions are made collaboratively and include all major stakeholders
- appropriately skilled staff are available, and
- the 'back end' of an organisation is working efficiently

Research from the Brookings Institution supports this contention.^{1,2}

"Relatively small investments in capacity building can improve organisational capacity, which, in turn, can produce significant gains in output such as staff morale, management focus, public reputation, efficiency and productivity."¹

Building the capacity of the sector will enable it to operate more strategically and efficiently

1. Brookings Institution (2005), *What It Takes to Make Charities Effective*
 2. Brookings Institution (2004), *Sustaining Nonprofit Performance: the Case for Capacity Building and the Evidence to Support It*

Although, as Sylvain Giguere (LEED Program, OECD)⁵ says, existing frameworks are a result of historic development and hence are often difficult to alter, it should be expected from the above information that on-going change *will* continue to be driven from Government to the health and community sector, with agencies being encouraged to either integrate or work together in partnership.

Effectiveness of Partnerships

Konrad⁶ as discusses systematic integration initiatives in the human service delivery field. She identifies different levels of integration, viewing them as a continuum that moves from informal to formal arrangements:

1. Information-sharing and communication: at this level, collaborative partners share general information about programmes, services and consumers (e.g. a working party involving public mental health service staff and community health centre staff to develop and implement projects relating to mental health issues).
2. Cooperation and coordination: here, partners work collaboratively to improve relevant services (e.g. private psychiatrists and GPs having reciprocal referral arrangements; public psychiatric inpatient facilities discharging consumers to GPs for follow up).
3. Collaboration: at this level, partners share activities in an effort to achieve a common goal (e.g. written agreements between public mental health services and community health centres; staff rotations and educational exchanges at public and private

⁵ **Partnership, Governance and the Economy: Practice ahead of Theory**, Sylvain Giguere Deputy Head Local Economic and Employment Development, OECD, Keynote paper, Governments and Communities in Partnership conference,

Centre for Public Policy, University of Melbourne 25- 27 September, 2006

⁶ Konrad E. A multidimensional framework for conceptualising human services integration initiatives. *New Directions for Evaluation* 1996; 69:5–20.

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mental health facilities).

4. Consolidation: a consolidated system involves a single umbrella organization, under which separate entities provide care (e.g. provision of public mental health sector services and community health centre services under the auspices of an Area Health Service).
5. Integration: at this level, there is a single authority that comprehensively addresses consumer needs, coordinates activities and has uniform eligibility criteria (e.g. pooling of public-sector funding with Medical Benefits Schedule (MBS) and Pharmaceutical Benefits Schedule (PBS) expenditure associated with private practice as a means of coordinating public and private mental health services).

Evaluation issues and ways of addressing them

Pirkis et al's paper⁷ provides a conceptual framework for developing, implementing and evaluating programmes concerned with linkages. They say that evaluation of programmes to address poor linkages is essential to guarantee that individual programmes are effective, and to ensure that lessons from these individual programmes can contribute to the body of knowledge regarding how best to improve linkages. There is a dearth of evaluative research examining the impact of collaborative programmes on consumer outcomes^{8 9}.

Knapp¹⁰ summarises three key issues associated with evaluating collaborative initiatives: (i) ensuring that the perspectives of all players in the collaborative programme are represented in the

⁷ Jane Pirkis, Helen Herrman, Isaac Schweitzer, Alison Yung, Margaret Grigg, Philip Burgess, **Evaluating complex, collaborative programmes: the Partnership Project as a case study**, Jane Pirkis, Senior Research Fellow (Correspondence) Program Evaluation Unit, Centre for Health Program Evaluation, School of Population Health, University of Melbourne, PO Box 477, West Heidelberg, Victoria 3081, Australia.

⁸ Hoge MA, Howenstine RA. Organizational development strategies for integrating mental health services. *Community Mental Health Journal* 1997; 33:175–187.

⁹ Henneman EA, Lee JL, Cohen JL. Collaboration: a conceptual analysis. *J. of Advanced Nursing* 1995; 21:103–109.

¹⁰ Knapp MS. How shall we study comprehensive, collaborative services for children and families? *Educational Researcher* 1995; 24:5–16.

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evaluation; (ii) specifying what is measured in the evaluation: examining processes may be just as important as measuring impacts and outcomes; and (iii) attributing effects to causes, which is often made difficult by the fact that collaborative initiatives are multifaceted and operate within already-complex systems.

Knapp (1995) considers how best to address these issues, suggesting that to be most helpful, evaluations should be:

1. Strongly conceptualised: the complexity of collaborative programmes and the resultant difficulties in terms of attributing cause and effect, mean that it is crucial that the evaluation explicates the causal linkages between elements of the programme at the outset. In the evaluation literature, doing this is known as clarifying the programme's logic or its theory of action¹¹.
2. Descriptive: because different players interpret the nature of collaboration differently, it is important that the evaluation provides detailed descriptions of the elements of the collaborative programme (e.g. structural arrangements, informal and formal collaborative mechanisms, pathways to care for consumers and the experience of collaboration for consumers, carers and providers).
3. Comparative: the evaluation should offer insights into the extent to which collaborative arrangements improve the experiences of consumers, carers and providers. They should provide information about the range of factors that augur well for or militate against collaboration working effectively.
4. Constructively sceptical: the evaluation should be wary of the 'hype' associated with collaboration, and acknowledge that there may be negative impacts or outcomes as well as positive ones (e.g. improvement in the joint operation of the two sectors may

¹¹ Patton MQ. *Qualitative evaluation and research methods*, 2nd edn. Newbury Park: Sage, 1990.

occur at the expense of the individual operation of each sector).

5. Positioned from the bottom up: the evaluation should be anchored at the level of consumers and carers (i.e. the ultimate recipients of the collaborative programme). This is not to say that the evaluation should be solely concerned with consumers' and carers' perceptions (although these are clearly important). Rather, it is about ensuring that there is a balanced approach that considers service and system benefits at the ground level.
6. Collaborative: where possible, the evaluation should be collaborative, engaging input from all players to incorporate a range of perspectives.

Partnership Evaluation Tools

In 2006 Jonathan Pietsch, Manager of Inner East Primary Care Partnership (PCP) and Executive Officer of the Statewide Chairs Working Group, used a Vincent Fairfax Churchill Fellowship to study primary health care partnership program/models that are developing solutions to provide coordinated and quality services for the aged with chronic/complex care needs. He explored collaborative partnerships in the United Kingdom, Canada, New Zealand and the United States (New York). He studied three types of partnership:

1. Three Facilitative Partnership arrangements
 - a. Healthy Communities Coalition – Canada
 - b. Wellesley Institute – Canada
 - c. Aged Care Change Management Team – England
2. Two Specific Purpose Partnerships
 - a. Managed Clinical Networks – Scotland
 - b. Local Strategic Partnerships

3. Four Area Based Health & Care Service Provider Networks
 - a. Community Health Partnerships – Scotland
 - b. Primary Care Trusts – England
 - c. Local Health Integrated Networks – Toronto
 - d. District Health Boards & PHO's – New Zealand

Pietsch asked questions about partnership history, context, stated purpose, key stakeholders, board makeup, resources, prevention/treatment focus, performance management, evaluation, key successes, concerns/failures, leadership and future directions¹².

A product of Pietsch's study is an analysis of a number of partnership evaluation tools that are designed to consider the complex process of evaluation of collaborative partnerships mentioned above¹³.

These tools are:

1. What makes a good partnership? Hardy et al. (UK)
2. Improving partnership practice. Markwell (UK)
3. The Wilder Collaboration Factors Inventory- Assessing Your Collaborations Strengths and Weaknesses- (Canada)
4. Vic Health Partnership Analysis Tool for Health Promotion- Australia
5. New York – Partnership Self Assessment Tool

Pietsch compared these tools in terms of:

1. Their validity and reliability
2. The quality of the questionnaire

¹² Churchill Fellowship – Presentation to Statewide PCPs – Chairs & managers – 7/12/06

¹³ Powerpoint presentation to Statewide PCP Chairs & Managers Meeting 1/2/07 – Partnership Evaluation Tools - From the UK, Canada and Australia Feb 2006

3. Its ease of use, and

4. The degree to which it promotes discussion

The table below shows his findings.

	EVIDENCE	QUEST- IONNAIRE	EASE OF USE	PROMOTES DISCUSSION
New York	1	High	Simple	<input checked="" type="checkbox"/>
UK – Hardy	3/4	Med/low	Lengthy	<input checked="" type="checkbox"/>
UK- Markwell	2/3	Med/low	Expert	<input checked="" type="checkbox"/>
Wilder Collab.	2	Med	Purchase	<input checked="" type="checkbox"/>
Vic Health	3/4	Med	Simple	<input checked="" type="checkbox"/>

Of the New York Partnership Self-Assessment Tool he noted the following in its favour:

- Evidence – High – 63 partnerships used it successfully
- Evidenced based hypothesis- Lit review
- Leadership & Partnership efficiency – 2 key partnership characteristics associated with successful partnership work.
- Leadership- key elements- Inspiring and motivating, common language, environment for difference, conflicts resolved
- Partnership efficiency-resources and partners time used well.

The Partnership Self-Assessment Tool was developed by the The Centre for the Advancement of Collaborative Strategies in Health at The New York Academy of Medicine. In 2001, the Centre conducted the National Study of Partnership Functioning¹⁴. This methodologically rigorous study of 63 partnerships throughout the United States (involving 815 partnership participants) was designed

¹⁴ PSAT Coordinator Guide www.partnershiptool.net/psat.html).

to determine the extent to which partnerships achieve synergy and to identify the factors that influence the ability of partnerships to maximise synergy. The study indicated that partnerships with a high level of synergy have a special kind of *leadership*, which promotes productive interactions among diverse participants, as well as the ability to make good use of their participants' in-kind resources, financial resources, and time (which we call *partnership efficiency*). The study also found high levels of synergy to be related to certain kinds of *administration and management* capacities, which are very different from bureaucratic forms of management, and to the ability of partnerships to obtain *sufficient non-financial resources* from their participants (e.g., their skills, information, connections to people and groups, endorsements, and convening power).

The report generated by the evaluation process used in the PSAT generates information on:

1. Our partnership's synergy score – an important indicator of the success of our collaborative process,
2. Our Partnership's strengths and weaknesses in areas that are know to be related to synergy, e.g.,
 - The Effectiveness of our Partnership's Leadership
 - The Efficiency of our Partnership
 - The Effectiveness of our Partnership's Administration and Management
 - The Sufficiency of our Partnership's Resources
 - Our Partnership's Non-Financial Resources
 - Our Partnership's Financial and Other Capital Resources
3. Our partner's views about their own participation in the partnership e.g.,
 - How our Respondents View the Partnership's Decision-Making Process

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- How our Respondents View the Benefits and Drawbacks of Participation
- How Satisfied our Respondents are with their Participation in the Partnership, and

4. Conclusion: How to use the information in this assessment report.

Primary Care Partnerships are Making a Difference

Commitment to the development of partnerships in the service sector by the Victorian Government is seen in its recent paper describing the impact of Primary Care Partnerships.

“Strengthening the human service system is a priority of the Victorian Government. Evidence from Australia and overseas demonstrates the value of partnerships in achieving this priority and improving the delivery of human services. Here in Victoria we have seen the positive impact of working in partnership over the past 6 years through the Primary Care Partnership Strategy.

Since the Primary Care Partnership Strategy commenced in 2000, we have seen agencies working together to improve the experience of consumers. Primary Care Partnerships (PCPs) are made up of a diverse range of member agencies. As can be seen by the figure opposite, all PCPs include hospitals, community health, local government and divisions of general practice as core members of the partnerships.

Other types of agencies such as area mental health, drug treatment and disability services are also members of PCPs. The partners can also be specific to local issues and needs. For example, some PCPs have engaged with the police, schools and community groups. PCPs are well established as a flexible and robust platform for partnership work in Victoria.

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Victoria now leads the way in Australia with our system-wide approach to working in partnership. Over the past 6 years, PCPs have focused on building relationships between agencies, service system reform, better coordination of services and an integrated approach to health promotion. We have clear evidence that the Victorian approach to partnership has improved our human service system through better continuity of care, a more responsive system, and greater efficiency”¹⁵

FMPPCP Partnership Work

Frankston Mornington Peninsula Primary Care Partnership, as part of its’ Community Health Plan 2006 – 2009, will conduct an in-depth review of its effectiveness as a voluntary alliance of 29 member agencies to determine how it is best placed to achieve its strategic priority of mental health and wellbeing (specific focus on family violence and social inclusion¹⁶).

Mental Health and Wellbeing is more often regarded as a health promotion priority rather than as a strategic priority for a whole primary care partnership. However, the issue of family violence in particular, in the Frankston Mornington Peninsula sub region is of magnitude to require strategies to address it across all the four sections of PCP activity: Partnership Development, Integrated Health Promotion, Service Coordination and Chronic Disease Management

The FMPPCP will not address family violence as a sole issue but rather as a strategic priority within the primary health issues and conditions that it normally addresses, such as for example, chronic disease.

In its partnership activity it will seek to develop effective networks

¹⁵ Primary Care Partnerships are Making a Difference, Dept Human Services, Victoria, 2007

¹⁶ See literature review accompanying section 2 of the FMPPCP Community Health Plan 2006-09 Integrated Health

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across the sector of primary health, community care and family violence in order to improve mental health and wellbeing for all. In its health promotion work it will seek to bring key stakeholders together to develop an action plan that provides services across the whole of the health promotion continuum. In terms of service coordination, the FMPPCP considers that the primary care partnership initiative has a lot to offer child and family (violence) agencies in terms of a single common system that works across sectors rather than just within them. Agencies within the PCP who deal with chronic disease are pleased to see an opportunity for them to address family violence and other mental health and wellbeing issues as they are issues that are often included in the complex care plans they design.

The PCP will review its Memorandum of Understanding¹⁷ to ensure that the structure of the PCP is optimal for its achievement of the aims, goals and objectives of its plan.

Promotion

¹⁷ Wikipedia online describes a memorandum of understanding (MOU) as a legal document describing a bilateral agreement between parties. It expresses a convergence of will between the parties, indicating an intended common line of action, rather than a legal commitment. It is a more formal alternative to a gentlemen's agreement, but generally lacks the binding power of a contract. http://en.wikipedia.org/wiki/Memorandum_of_understanding

3. Achieving the vision: *Capacity Building Plan*

Element: Leadership (if using capacity building elements)

Strategic Goal	Objective	Strategies/ Interventions	Action	KPI	Estimated Impact	Time Line	Progress Notes
To build an informed and responsive environment of existing and new partnerships, in order to improve mental health and wellbeing (specific focus on family violence and social inclusion) in the Frankston Mornington Peninsula sub-region.	To strengthen the FMPPCP's ability to achieve its strategic goal.	Use the New York Partnerships Self Assessment Tool (PSAT) to evaluate the effectiveness and efficiency of FMPPCP – in terms of its synergy: i.e., its leadership, efficiency, administration & management, and benefits and drawbacks from participating in the PCP	Engage consultant with research expertise to conduct the PSAT with actively participating PCP member agencies to develop some pre-test data on PCP member agency perceptions on the effectiveness and efficiency of the FMPPCP	Base-line data about effectiveness of FMPPCP with recommendations arising from the first report	Engagement of 70% of active member agencies in PCP change process	June/July 2007	
			Circulate pre-test data to member agencies and run one or more forums to discuss, decide and implement changes in the partnership's operation that arise from the pre-test report	Implementation of changes arising from pre-test report	70% of total PCP membership engaged in change process	July – September 2007	
			Engage consultant with research expertise to conduct the PSAT to develop post-test data on member agency perceptions of the effectiveness and efficiency of the FMPPCP	Measurement of effectiveness of partnership against pre-test data and following implementation of changes arising from original report	70% improvement in terms of synergy of the FMPPCP	April May 2009	
		Review and adapt the Partnership's Memorandum of Understanding to	Governance committee to develop a new MOU incorporating optimal structure for PCP to achieve its strategic goals	Revised MOU and PCP structure put to PCP membership and endorsed	Improved governance structure for PCP	March 2007	

	enable the PCP optimal opportunity to achieve its strategic priorities	Hold a member agency forum to launch new CHP and endorse MOU				May 2007	
	Set and implement an integrated two year family violence plan involving partnership across relevant sectors – e.g., primary health, child and family, family violence (incl. police/ courts)	Bring key stakeholders together to:				July 2007	
		- map current services and gaps, - map connectivity gaps and - identify areas for improvement.	Local needs and opportunities identified	Integrated family violence planning partnership established			
		Conduct a literature review to establish best practice in related to integrated family violence strategies	Best practice identified	Two year plan can be developed on a sound footing	June 2007		
		Integrated Family Violence Partnership Plan developed	- Plan developed and agreed to - Tasks documented and assigned to partners	• Clear roles and responsibilities for decision making and the completion of partnership activities documented	August 2007	•	
		Conduct a second forum to present Integrated Family Violence Partnership Plan to	- endorse plan - identify and allocate tasks to all partners	• Responsibility for achieving Partnership goals shared amongst partners	September 2007	•	
	Partner agencies determine skills and authority required to	Skills and authority determined and ready to assign	• Relevant family violence objectives	November 2007			

			appropriate individuals/teams	tasks to individual / team plans	implemented by partners		
			Tasks included in partner agency individual / team annual work plans	Tasks assigned to appropriate individual / team workplans		March 2008	
		Explore the appropriateness of encouraging PCP member agencies (i.e., Community Health & Women’s Health and HACC funded agencies) to implement a gender and diversity QI lens to program planning, implementation and evaluation	Participate in DHS Gender & Diversity Template Steering Group, representing Statewide PCP Chairs and Managers Network	Member agency awareness and introduction to G&D Template / tool kit	DHS funded agencies have informed knowledge of gender and diversity QI tool and can make informed decisions about implementation.	September 2007	
			Pilot Gender & Diversity Template/Tool kit in FMPCPC member agencies mandated by DHS to use them.	Pilot conducted		July 2008	
		Embed relevant MPHP social inclusion objectives and strategies in relevant PCP member agency plans	PCP social inclusion workplan developed and agreed to by member agencies	Plan developed and agreed to	<ul style="list-style-type: none"> • Clear roles and responsibilities for decision making and the completion of PCP activities documented • Responsibility for achieving PCP goals shared 	November 2007	•
			Tasks associated with PCP social inclusion work plan documented and assigned to member agencies	Tasks are documented and assigned to member agencies			
			Member agencies determine skills and authority required to undertake PCP tasks and assign to appropriate individuals/teams	Skills and authority determined and ready to assign tasks to individual / team plans		March - June 2008	

			Tasks included in member agency individual / team annual work plans	Tasks assigned to appropriate individual / team workplans	<p>amongst PCP members</p> <ul style="list-style-type: none"> Relevant MPHP social inclusion objectives implemented by PCP member agencies 		
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Element: Capacity Building

Goal	Objective	Strategies/Interventions	Time Line	Estimated Impact	Progress Notes
To strengthen and support member agencies' ability to respond to family violence and its attendant issues	To support a network of primary care health professionals in building family violence strategies (across the health promotion continuum) into their program/s and plans.	One member agency family violence forum	annually	A trained workforce across the sub-region with consistent understanding and skills in relation to recognition and response to family violence	
		Use of DVIRC family violence training program	Two or three training programs (basic and advanced) offered per year 2007 - 2009		
		Promote/Engage with the Family Violence Clinical Network on the Frankston Mornington Peninsula			
Enhance and	Build partnership	Participate in primary	2007 - 2009	PSAT evaluation of	

strengthen the partnership management skills of the FMPPCP	management capacity for Chair, Governance Committee & Executive Officer	care management training as offered by DHS		Partnership shows enhanced synergy of FMPPCP	
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4. List of FMP PCP member agencies/organisations and explanation of membership types

Agency name	Type of membership	Deliverable/s involved in
Baptcare	Full	3
Brotherhood St Laurence	Full (Chair: Implementation Committee)	1, 2 ,3
Bunurong Agoriginal Health Service	Full	
Do Care Southern	Full	3
Extended Families Australia	Full	
Frankston Community Support and Information Centre	Full	
Frankston City Council	Full (Implementation Committee)	1, 2, 3
Good Shepherd Youth & Family Services	Full	3
Impact	Full	
Mental Illness Fellowship Victoria	Full	
Menzies Inc.	Full (Implementation Committee)	1, 2
Mornington Peninsula Division General Practice	Full	1, 3,4
Mornington Peninsula Shire Council	Full (Implementation Committee)	1,2,3

Mount Eliza Community Contact	Full	1, 3,
Peninsula Community Health Service	Full (Implementation Committee)	1, 2, 3, 4
Peninsula Health Service:	Full (Implementation Committee)	1, 2, 3,4
Ageing Well Centre		3, 4
Falls Prevention Service		2, 3, 4
Frankston Community Health Service		1, 2, 3,4
Peninsula Complex Care Program		2, 3, 4
Stay Healthy Program		2, 3,4
Integrated Care Program		3
ME ACAS		2
Psychiatry (adult)		2
Peninsula Hospice Service	Full	
Peninsula Support Service	Full	
Relationships Australia	Full	
Richmond Fellowship of Victoria	Full	
Royal District Nursing Service (Frankston & Rosebud Centres)	Full (Implementation Committee)	1, 3, 4
South East Centre Against Sexual Assault	Full	3
Seniors Pty Ltd	Full	
South Central Region Migrant Resource Centre	Full	1, 2
Southern Peninsula Community Care	Full	
Vision Australia: Southern	Full	
Women's Health in the South East	Full	1, 2
Wongabeena Association	Full	