Working together

collaboration for health

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A PRACTICAL GUIDE

UNSW SYDNEY

NSW GOVERNMENT Health Sydney Local Health District

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The context

THE AUSTRALIAN HEALTH SECTOR has long experience in collaborating, both within the sector and with other sectors (or parts thereof), in actions to reduce risks to health, to prevent illness and injury, or to promote health and health equity. In Australia and across the world, many such collaborations have contributed to improving the health and wellbeing of populations. Collaboration has been recognised as being essential in enabling organisations and sectors to achieve health and other social and economic goals.

However, collaborations do not always live up to their promise in practice and can falter or fail before they have been able to achieve their intended goals. Over decades, evidence has grown of factors that influence the likelihood of success (or failure), and practice has become both more ambitious and more sophisticated.

As one part of the Australian health sector, the Sydney Local Health District (SLHD) has had extensive experience in collaborating within the sector and with other sectors. The Inner West Interagency Partnership and Planning Group (IWIPPG) is one example of a collaboration in which organisations and their representatives from several sectors successfully prepared and implemented a Child Health and Wellbeing Plan.[1] The IWIPPG engaged the SLHD's Health Equity Research and Development Unit (HERDU) to support the implementation of the Plan and to identify factors that would assist in sustaining the collaboration into the future. With ethics approval from the SLHD and the University of New South Wales (UNSW), HERDU conducted two consultative workshops and carried out in-depth interviews with IWIPPG members and other key stakeholders engaged in collaborations with the SLHD.

The synthesis of discussions at these two workshops and analysis of the interviews, together with the experience and wisdom of the skilled workforce and an extensive review of the literature, have been distilled by the authors to update the conceptual framework outlined in their earlier publication.[2]

All the quotes in this Guide have been approved by their sources.

Glossary

THE BODY OF KNOWLEDGE informing collaboration for health is evolving – drawing on an expanding range of disciplines and evidence. That can mean that the language used to describe and explain core concepts and elements of collaboration for health can be confusing. In this section we explain the definitions/explanations as they have been used in this Guide.

Authorising environment

Potential parties to a collaboration operate within political, economic, social and cultural contexts that make up their authorising environments. A positive authorising environment provides legitimacy and support for organisations (and people) to enter a collaboration to achieve their objectives.[54] An authorising environment can also present barriers to parties entering a collaboration. The extent to which environments authorise collaboration is not fixed for all time, but rather, changes in response to changes in public policy or personnel, or public demand for action on an issue of concern.

Boundary spanners

Collaborations inherently require their participating organisations and people to work together across organisational and inter-personal boundaries. Boundary spanners are people who operate at the intersection between the different organisations and people, and who have both personal attributes and competencies that enable them to bridge differences by building trust, fostering equitable decision-making and outcomes, and reconciling diverse interests.[3]

Collaboration (1)

Between individuals

'Collaboration is a process through which parties who see different aspects of a problem can constructively explore their differences and search for solutions which go beyond their own limited vision of what is possible'.[4] In this definition, the parties engaging in the collaboration are assumed to be individuals.

Collaboration (2)

Between organisations

'A recognised relationship between a part or parts of the health sector with part or parts of another sector that has been formed to take action on an issue to achieve health outcomes or intermediate health outcomes in a way that is more effective, efficient, sustainable or equitable than could be achieved by the health sector acting alone'.[5] In this definition, the parties engaging in the collaboration are assumed to be organisations, including community organisations.

Core business

'The primary activity which defines an organisation's main emphasis and for which the organisation exists'.[6]

Equality

Equality is the principle of uniform apportionment; it does not imply identity or sameness. The term is interpreted differently by different people, depending upon what they assume or say is being apportioned. The four interpretations are:

(i) foundational equality – human beings are 'born equal, our lives are of equal moral value';

(ii) formal equality – expressed as equal rights and entitlements;

(iii) equality of opportunity – everyone has the same starting point, equal life chances; and

(iv) equality of outcomes – equal distribution of rewards.[7]

Equity

Equity is defined as the quality of being equal or fair, of fairness, or impartiality, or even-handed dealing.[8]

Governance

Governance is how society and groups within it, organise to make and implement decisions of public importance.[9] The governance of a collaboration (or any organisation) is comprised of the structure and processes through which decisions are made about 'how we do things around here'? Who has power? Who makes decisions? How stakeholders make their voices heard? And how account is rendered?[10] In this Guide, governance is assumed to be a set of processes that are formally or informally agreed to and applied in order to distribute responsibility and/or

accountability among actors from within the health sector and from within those non-health sectors whose decisions influence health. [11, 12, 13, 14, 15]

Health equity

Health equity is the absence of avoidable or remediable differences in health among groups of people.[16] Health equity is the absence of systematic disparities in health (or in the major social determinants of health) between groups with different levels of underlying social advantage/ disadvantage; wealth, power or prestige.[17]

'Health equity is achieved when every person has the opportunities (goods, services, and full participation in society) necessary to attain their full health potential, and when no-one is unfairly and unjustly disadvantaged from achieving this potential because of their social position or other socially determined circumstances'.[18]

Health inequity

Health inequity arises when social groups are systematically and persistently denied fair and just access to the social resources and opportunities that are essential to become and stay as healthy as possible.[19]

Health and wellbeing

Health has been defined as a characteristic of both individuals and whole communities. It can be defined as the absence of disease or as the presence of wellbeing.

a. 'Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.' Preamble to the Constitution of WHO as adopted by the International Health Conference, New York, 19 June - 22 July 1946*

b. Health is 'the social, emotional and cultural wellbeing of the whole community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total wellbeing of their community. It is a whole-of-life view and includes the cyclical concept of life-death-life'.[20]

Interorganisational collaboration

Interorganisational collaboration 'is a process used by committed stakeholder organisations within a problem domain to solve messy or complex issues'.[21]

Intersectoral action for health

Intersectoral action is a term used commonly by the health sector to describe 'a recognised relationship between part or parts of the health sector with parts of another sector which has been formed to take action on an issue to achieve health outcomes (or intermediate health outcomes) in a way that is more effective, efficient or sustainable than could be achieved by the health sector acting alone'.[22]

Parties (to collaboration)

The parties to collaboration are organisations and people. The organisations may be from the public, private, non-government or community sectors. The people are representatives of the organisations.

Power

At its simplest, power is defined as the energy or capacity to take action to change things or to produce an effect – to influence or change an outcome. Personal power is the capacity of individuals and is essential to individuals' agency or self-mastery. Social power is the capacity that is necessary to enable groups, organisations and systems to take collective action to make a difference in the social world.[23]

Popay et al. developed an Emancipatory Power Framework that identifies 'power within', 'power with', 'power to', and 'power over' as forms of power that are available to and needed by communities to enable them to exercise self-determined collective control over social decisions. [24] Popay et al. also developed a Limiting Power Framework that identifies 'compulsory power', 'institutional power', 'structural power', and 'productive power' as forms of power that are available to social institutions to fulfil their social mandates, and that also enable them to limit the power of external groups (communities or organisations) to engage in and influence social decisions.

Acronyms

CE
Chief Executive

CEO
Chief Executive Officer

CGHiC
Can Get Health in Canterbury

DCJ
NSW Department of Communities & Justice

EFHIA
Equity Focused Health Impact Assessment

FACS
NSW Department of Families and Community Services

HERDU
Health Equity Research & Development Unit

HHAN
Healthy Homes and Neighbourhoods

HIA
Health Impact Assessment

HiAP
Health in All Policies

IWIPPG
Inner West Inter-Agency Partnerships and Planning Group

LGBTQIA
Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual

LGA
Local Government Area

LHD
Local Health District

MOU
Memorandum of Understanding

NGO
Non-Government Organisation

PHN
Primary Health Network

SLHD
Sydney Local Health District

UNSW
University of New South Wales

Introduction to the Guide

Organisations and people working together to solve complex problems

COLLABORATION both between health and other sectors and within the health sector has long been recognised as essential for achieving continuous improvements in the health and life expectancy of populations and for increasing health equity.

Collaboration has been defined as 'a process used by committed stakeholder organisations within a problem domain to solve messy or complex issues'.[21] Another complementary definition describes collaboration for health as a recognised relationship between part or parts of the health sector and part or parts of another sector that has been formed to take action on an issue or to achieve health outcomes in a way which is more effective, efficient or sustainable than could be achieved by the health sector working alone.[2]

Collaborations form when an organisation or a group of people has recognised that it is not possible to resolve a complex problem from within their own mandate or capacity. The promise of collaborations lies in the view that when unusual partners collaborate, there is an opportunity for novel solutions to be generated. Innovative solutions can emerge when the right, but not always the usual, partners collaborate.

Collaborations mean that parties must work across sectoral, organisational, professional, cultural and personal boundaries. One consequence is that 'there is always creative tension between the self-interest and the collective interest' of the parties.[21] As well as seeking to collaborate with others to resolve a shared problem or problems, parties also seek to enhance their own capacities to conduct their own core business and to achieve their own goals.

'Building networks and working collaboratively makes a lot of sense and can deliver many things that are not possible by working alone. But they don't always happen organically or by magic. Most are hard to create and even harder to sustain. They are also not business as usual and require new ways of thinking, behaving, managing, leading and evaluating'.[28]

The purposes of the Guide

THIS GUIDE IS INTENDED for people and organisations that have identified a complex social problem that can only be resolved through collaboration with other parties, necessitating work across sectoral, organisational, professional and personal boundaries.

The Guide can be used prospectively, to guide the establishment of a collaboration, or retrospectively, to diagnose and resolve problems that may lead to the failure of an existing collaboration. It has been prepared to:

1. assist organisations and people to establish and sustain successful collaborations for health; and to
2. assist organisations and people who are already engaged in a collaboration, to diagnose and resolve problems that can prevent the collaboration from achieving its intended goals.

> "Collaborations form when an organisation or a group of people has recognised that it is not possible to resolve a complex problem from within their own mandate or capacity."

Understanding collaboration

> "Communities and consumers are being recognised increasingly as parties in collaborations for health."

COLLABORATION HAS LONG BEEN recognised by the health sector as being essential to protect, maintain and improve the health of populations and individuals, and to achieve health equity. Moreover, collaborations within health systems and between health sectors and other sectors, have resulted in significant improvements in the health and life expectancy of populations and individuals at national, regional and local levels.[26]

Although much has been learned about the factors that contribute to the success of collaborations, many collaborations still falter or fail to achieve their intended goals. In order to address the many complex health and social problems that persist both in Australia and globally, the necessity for the health sector to collaborate effectively within the sector and with other sectors, continues to be pressing.

The parties to any given collaboration are both organisations and people. The multiple determinants of health and health equity mean that multiple parties play roles in creating and/or resolving contemporary health problems. In any given collaboration parties may be from different parts of the health sector or from other sectors, such as education, housing, justice, transport or agriculture, for example. The parties may operate in the public or private sector and/or in the non-government or civil society sectors, they may be from a variety of

> “… collaborations … have resulted in significant improvements in the health and life expectancy of populations and individuals …”

professions or occupations, or from local communities and from different cultural and socioeconomic backgrounds.

The willingness and capacity of organisations and people to collaborate is influenced by their independent histories, roles, resources and reputations. Not all potential parties recognise or are prepared to commit to collaborating to improve the health of people and populations.

Organisations are established for specific social purposes and operate in a multitude of different policy environments with varied levels of power and authority. Each organisation has its own structure, form of governance, workforce and resources.[12] An organisation's need to preserve or enhance its resources and reputation can sometimes mean that working with others is viewed as being too risky.

In addition, people bring their own professional and cultural worldviews, their personal values, pre-existing relationships, experiences and aspirations to collaborations. An individual's biases are often implicit, but these too, shape their contributions.

People can initiate collaborations with little reference to their organisations or constituents. However, the power of collaborations to achieve changes in policies, practices or environments for health requires that people engaged in a collaboration have the authority and commitment of their organisations to do so. As representatives of their organisations, people's contributions are shaped not only by their individual values and beliefs, but also by their organisations' norms, values, goals and resources.

In short, all collaborations are formed by parties whose goals, histories, resources, obligations and biases shape their expectations of what they are seeking from a collaboration and influence what they are able to contribute to collective action.

Understanding underlying reasons why parties can seem reluctant to engage in, or choose to withdraw from, or disrupt the work of a collaboration, is a necessary precursor to identifying positive ways forward. The reasons are not always obvious at first glance.

Health sectors are intricate and elaborate networks of health organisations, each with a unique structure and objectives.[12] In its size and complexity, a modern health sector (including its associated bureaucracy) is a microcosm of society.[32]

“The health workforce is comprised of people that have widely varying roles and training … and who come from diverse cultures, language groups, histories and experiences.”

Multiple organisations make up the Australian health sector, including General Practices, Aboriginal Community Controlled Health Organisations, Non-Government Organisations (NGOs), hospitals and community health centres, and community organisations such as the Consumers' Health Forum. Different parts of the sector are administered by different jurisdictions (Commonwealth, State or local), and are funded from different sources, such as the public or private sector, philanthropists or communities.

Health sectors employ people from multiple occupational groups.[31] The health workforce is comprised of people that have widely varying roles and training, do not necessarily share similar values, and who come from diverse cultures, language groups, histories and experiences. All these factors contribute to biases that influence their decisions.

The health sector's emphasis on scientific evidence (often narrowly defined) to guide policy and practice, can mean that parties from within the health sector bring little knowledge of, or respect for, types of evidence that are used by organisations and social groups from other sectors in making their policy and practice decisions.

The administrative boundaries defining the geographic areas for which organisations from the health sector are responsible are often different to the boundaries used by other sectors, complicating the process of collaboration.

The power and size of the health sector and its capacity to act autonomously, can mean that parties from within the health sector may be unfamiliar with, or uncomfortable about, acknowledging that decisions made by other sectors also play critical roles in determining the health of populations. Conversely, other sectors' perceptions of the power and size of the health sector and the level of resources it controls, can make them reluctant to commit their own resources to working together.

For all these reasons, the Australian health sector's structures and ways of working are not necessarily transparent to parties from other sectors.

It is not uncommon for some parties to collaborations to act as 'passengers' or 'free riders', seeking to accrue benefits without contributing resources (including time

or consistent participation), or failing to implement planned actions. Free riding is often a result of power imbalances between parties, for example when a dominant party seems to overwhelm or ignore differences in the capacity of other parties to participate, or when a party agrees to participate primarily to protect its own interests. Such power imbalances may not be readily transparent to all the parties in a collaboration.

Communities and consumers that have vital interests in the effectiveness of the health sector and in health equity, are being recognised increasingly as parties in collaborations for health. However, often such communities and consumers have been marginalised from full participation in society and they may not yet be sufficiently organised to enable them to take part as the equal of other parties that have power to set their own agendas and to influence collective decisions. Further, despite a long history in public health and health promotion of community organising and community participation, such initiatives can still leave communities 'outside' collaborations in which social organisations make decisions about policies, practices and distribution of resources. To address this, new ways of working that include actively sharing power with marginalised communities are emerging.[40]

Collaboration, both between the health and other sectors and between organisations and people within the health sector, is a necessity for the health sector to achieve its goals.

Collaboration requires parties (organisations and people) to work together to identify and achieve a goal that would be unattainable by any single party working alone. When a collaboration forms, organisations and people that make different contributions to problems and solutions, are brought together. Agreeing to collaborate means that parties must take risks in order to achieve both shared and individual benefits.

When risks are calculated as being too high for any particular party, that party may decide not to participate, or they may agree to participate 'in principle' and 'in public', but fail to contribute in practice. Reluctance or lack of participation is often interpreted by other parties as criticism, obfuscation or competition. If unresolved, this can lead to conflict and result in failure.

"Communities and consumers that have vital interests in the … health sector and in health equity, are being recognised increasingly as parties in collaborations for health."

A conceptual framework: the core elements of collaboration for health

THIS CONCEPTUAL FRAMEWORK draws on theory and evidence from a variety of disciplines, to describe and explain the range of factors that make it challenging for organisations and people to collaborate effectively for health. [12]

Each of the elements in the framework constitutes a point at which differences between parties must be negotiated, although the negotiation may not be overt or transparent. The different goals, resources, expertise and experiences that parties bring to collaboration are vital to success, but they can also be barriers. This conceptual framework is intended to assist parties to identify actions that can increase the likelihood of success, or that can reduce the likelihood of conflict or failure by resolving problems if they arise.

Why collaborate?

Collaboration, both between the health and other sectors and between organisations and people within the health sector, is a necessity for the health sector to achieve its goals.

Collaboration brings together parties who have recognised that collective action is a necessity that will also enable them to conduct their own core business and achieve their own goals.

Why now?

Parties identify opportunities to achieve their own goals by collaborating with others.

Or, having identified a lack of opportunities to collaborate now, parties may take action to create opportunities, or decide to wait (on alert) for opportunities to arise.

What does a collaboration look like?

Each of the member organisations enters a collaboration with their own, pre-existing structure, form of governance, norms and goals. People also enter with pre-existing personal and professional values, competencies and goals.

A collaboration is a new structure (organisation) with its own governance and a new network of people and interpersonal relationships, the form, intensity, duration and power of which is negotiated by members.

Although the interests and commitment of pre-existing structures and networks may be congruent, there may be wide gaps and tensions that are not immediately transparent.

What capacity does a collaboration need?	**WORKFORCE:** A mix of people who, collectively, bring the range competencies necessary to carry out the maintenance and production functions necessary for a collaboration to achieve its goals. **RESOURCES:** Financial resources and infrastructure that are sufficient to support the workforce and the work for the time needed to achieve a collaboration's goals.
What is the work?	**MAINTENANCE FUNCTIONS:** building and sustaining trusting interpersonal and inter-organisational relationships, developing and maintaining effective communication and preventing and resolving conflict. **PRODUCTION FUNCTIONS:** creating shared meanings and understandings about problems, their determinants and their solutions; jointly forming plans or policy statements to implement the solutions; establishing roles and responsibilities for action and implementation.
What actions are carried out?	**IMPLEMENTATION:** translating plans into action. **MAINTENANCE FUNCTIONS:** routine communication and reporting within the collaboration and among each of the parties; active management of relationships; and implementation of conflict resolution measures as required. **PRODUCTION FUNCTIONS:** establishing an implementation review mechanism; assigning implementation responsibilities; routine reporting; and sustaining problem resolution mechanisms.
Did it work?	**MONITORING:** monitor the quality of the collaboration to assess the likelihood of sustainability. **PROCESS EVALUATION:** assess whether the actions that were planned have been implemented. **IMPACT EVALUATION:** assess whether the objectives of planned actions were achieved. **OUTCOME EVALUATION:** assess the cumulative effect of all actions taken and whether the shared goal was achieved. **ASSESSMENT OF BENEFITS:** assess benefits for each of the organisations that is a party to the collaboration.
Are the outcomes sustainable?	What procedures have been established to review progress and to monitor and identify actions necessary to sustain positive impacts and outcomes?

Why collaborate?

In brief

Collaborations are established to resolve serious and complex social problems that parties (organisations, communities and people) recognise they cannot achieve alone.

Parties take part in collaborations in order to:

- **achieve the goals of carrying out their own core business;**
- **attract resources and expand areas of influence;**

or

- **protect resources and existing areas of influence;**
- **increase profile, reputation, and prestige.**

PARTIES ARE MOST LIKELY to engage in collaboration when they recognise:

- their interdependence in resolving a complex social problem;
- that new solutions emerge by dealing constructively with differences;
- that joint ownership of decisions is involved; and
- that success may require the assumption of collective responsibility for the future direction of the domain (i.e. the issue of shared concern).[4, 53]

As well, parties that are in conflict over resources or domain are more likely to be open to collaboration than those that are not in danger of losing resources or control.[52]

In practice, parties may embark on a collaboration when they recognise shared or overlapping goals or concerns. However they may not yet have a clear focus for joint action.

In 2012, the Sydney Local Health District (SLHD) established a collaboration with the UNSW Centre for Primary Health Care and Equity in order to strengthen action and research on the role of a health sector organisation in improving health equity. The Health Equity Research and Development Unit (HERDU) began working with the SLHD by conducting an Equity Focused Health Impact Assessment (EFHIA) of a recently released SLHD

Strategic Plan. The EFHIA found that the Plan had not included any mention of child health among its recommendations, despite the SLHD having a strong commitment (in principle) to improving child and adolescent health.

The SLHD decided to take decisive action with other agencies that had a shared concern and responsibility for child health and wellbeing. Taking advantage of a realignment of their administrative boundaries, human service agencies in the inner west area of Sydney, established a collaboration between the SLHD, the NSW Department of Families and Community Services (FACS) (later in 2019, the NSW Department of Communities and Justice [DCJ]), and Medicare Locals (later, Primary Health Care Networks [PHNs]). This collaboration became the Inner West Interagency Partnership and Planning Group (IWIPPG). In addition to the alignment of the administrative boundaries, the broad policy environment was positive.

In the example below, representatives from the organisations that were the principal parties to the IWIPPG explain why their organisations agreed to collaborate.

EXAMPLE 1: WHY COLLABORATE?

A collaboration between the SLHD and FACS resulted in the establishment of the IWIPPG, initially for the purpose of helping representatives of each organisation understand the other's business operations, and to explore shared problems that could respond to joint action.

'It was mainly that we wanted to get to know and to build bridges with our counterparts in FACS'
(Senior Executive, SLHD).

'At the time the collaboration was established, the NSW Department of Premier and Cabinet was doing a lot of work to reduce health and social problems arising on social housing estates, and had expressed the preference to see joined up service delivery. So I know that this was certainly imprinted on a lot of senior executives and provided a strong authorising environment for us to collaborate with FACS in particular. Parts of the health sector had identified children and families as a priority group among the residents of social housing estates that required strengthened support and services'
(Senior Executive, SLHD).

'From a FACS perspective, there were two key functions that related to a child cohort [the population group that had been given priority by the health sector]. From a child protection perspective, the FACS role is to respond to children at risk of significant harm, and in those responses, develop pathways for families to resolve any child risk issues. Another part of our role is building interventions for child health programs. Two of the main reasons for FACS being involved were, to contribute in terms of our own funded service system and to help establish a generalised response from the broad system that would touch on the children and families that are priorities for both FACS and the child and family services within the health sector'
(Program Director, FACS/DCJ).

Through initial conversations, the two agencies identified a shared concern and a specific project.

'For the first project of the collaboration, we tried to choose something that we all had in common and we invited other agencies to join the group. We invited the NSW Department of School Education, the Central and Eastern Sydney Primary Health Network, and the Inner West Sydney Collaborative Practice Management Group. When the parties had joined we undertook an exploratory process to identify a shared concern and a goal that was aligned with the core business of each. The preparation of the Child Health and Wellbeing Plan for Inner Western Sydney was the first project undertaken by the collaboration.
'I remember the CE (from another sector) saying, "it cannot just be called a health [i.e. child health] plan, it has to include well-being". So they saw this side of things being encompassed, and that convinced them that it was an 'all-agency' thing. We put the wellbeing in'

(Senior Executive, SLHD).

In every collaboration, each party has its distinct core business to consider when deciding whether or not to collaborate with others. Parties bring different interests, values and power to collaborations.[50] Not all parties necessarily see or understand initially how their decisions contribute to health. Neither are all parties willing to risk their autonomy, resources, or reputation to contribute to improving health outcomes, unless they can also identify ways in which the collaboration will contribute to their own organisation's core business.

There may be many organisations engaged in a collaboration, or there may be only two. As well, depending on the problem to be addressed, different organisations and different people may be engaged at different points in the evolution of the collaboration's work.

The **Stay on Your Feet** initiative began with the identification of the broad range of parties that could contribute to a program to reduce injuries caused by falls among older people. The early development brought together people from professions and organisations with roles in preventing or treating injuries to older people caused by falls. Some of those involved were health professionals (medical practitioners, nurses, allied health workers, aged care workers, pharmacists, optometrists, public health and health promotion researchers, and equipment suppliers), urban planners and engineers, footwear manufacturers and retailers, and representatives from senior citizen organisations. Each party explained its sector or organisation's contribution to the problem and their potential contribution to its resolution. This initial meeting resulted in the formation of a collaboration that, in turn, resulted in a successful, comprehensive intervention that included actions taken by many of the parties involved.[54]

Why now?

PARTIES OPERATE within political, economic, cultural, and social contexts that constitute their authorising environments. These influence whether parties participate in a collaboration.[48] These contexts vary over time and are not always the same for all potential parties to a collaboration. Parties are more likely to collaborate when their authorising environments endorse their doing so. Examples are: when a change in government policy shifts in favour of collaboration; when access to increased resources makes collaboration possible; or when a significant, pressing problem occurs, e.g. a bushfire, that can clearly only be resolved through the actions of multiple organisations, sectors and people. Political will and commitment have been identified as being crucial for the initiation and maintenance of collaborations.[50]

The opportunity to engage in collaboration is also influenced by pre-existing relationships among potential stakeholder organisations and people that have created trust and have some shared experience.

However, opportunities to collaborate are not always immediately available to one or more of the stakeholder organisations, even when the necessity to work together has been understood and accepted by prospective parties. It may be necessary to create or wait for a positive authorising environment to emerge, or to prepare in advance so as to take advantage of a catalyst for collaborative action (e.g. an environmental crisis or an unforeseen pandemic).

In brief

Ready now?

- A positive authorising environment that legitimises and supports collaboration, is in place.
- catalysts are available.

They may include:

- ▲ an intermittent event such as a bush fire or an infectious disease outbreak;
- ▲ community concern or a social movement about an issue;
- ▲ a new way of thinking about the causes of a complex problem.

Getting ready for later?

However, it may be necessary to wait until:

- a positive authorising environment has emerged (e.g. policy change, change of personnel or new funding);
- you have worked with others to create a positive authorising environment;
- a catalyst emerges.

Different parties to a collaboration work in different contexts.

A positive authorising environment for one party may not be available to another party.

What is a positive authorising environment?

A POSITIVE AUTHORISING ENVIRONMENT provides the legitimacy, support and consensus that enables organisations to achieve their objectives.[54, 55] The organisations may be operating independently or through a collaboration.

The quotes below illustrate the impact of positive government policy on an organisation's agreement to participate in collaboration:

> *'We certainly had the Department of Premier and Cabinet wanting to see joined up service delivery, and that was imprinted on a lot of senior executives' minds around needing to create those opportunities to work together'*
>
> **(Program Director, FACS/DCJ).**

> *'The "future directions policy" and the priority given to social housing that is included in our 10-year plan, talked very much about place making strategies and better social housing experiences, and opened up opportunities for collaboration'*
>
> **(Program Manager, DCJ/Housing).**

Authorising environments can change rapidly; for example, when policy changes result in shifts in an organisation's core business or priorities, or when there are changes to key personnel in organisations that are members of a collaboration. Such changes can influence the willingness or capacity of organisations to collaborate.

What can be catalysts to action by the health sector?

SPECIFIC CATALYSTS arising in one or more sectors can also encourage and legitimise engagement in collaboration. The health sector experiences multiple catalysts, including problems or new ideas, that can lead to the sector working with others. Some of the catalysts include:

- an accidental or intermittent event such as a bush fire or an infectious disease outbreak;
- community concern or a social movement about an issue (e.g. climate change, domestic violence, racism or HIV/AIDS);
- new technology enabling improved access to medical expertise (e.g. social media);
- a new way of thinking about the causes of a complex problem (e.g. inequity in health), or new evidence regarding effective responses (e.g. Indigenous community engagement);
- the redefinition of an acceptable standard governing environments (e.g. toxic waste exposure or controls on tobacco smoking);
- legislative responsibilities or changes brought on by threats to funding, direction of superiors, spending money at the end of the financial year and trying to build on credibility gained through success in another area;
- a shift in the demographic composition of communities that increases the diversity of needs within a population.

A structural change within the health sector can be a catalyst for collaboration both within the sector and with communities to increase health equity.

> *'The establishment of the Medicare Local [now PHN], the establishment of Local Health Districts and a good relationship between the CEOs, plus the personal credibility of two leaders from the university and the health district, created an authorising environment for establishing the collaboration [that became Can Get Health in Canterbury (CGHiC)]'*
>
> **(Senior Manager, PHN).**

Community activism can also be a catalyst for collaboration, as in the following example of an initiative to establish a new service.

> *'This [a community NGO working with the health sector] is partly possible because of the redevelopment, so we're seizing the moment. Yeah, I would say that there was a coalescing of interest and that's led to some good things for the health sector and some good things for us.'*
>
> **(Co-spokesperson, Community NGO).**

In Example 2, a crisis (local community concern and unrest, and ultimately a murder) was the catalyst that led to collaborative action.

EXAMPLE 2: CATALYSTS FOR COLLABORATION

'The RedLink Hub was a well-established collaboration with strong relationships with the local community, and with a history of effective collaboration. The catalyst provided by escalating problems, resulted in looking to "do something a bit different". That led to the establishment of a stronger relationship between RedLink and the health sector at a time when the "health-funded" Healthy Homes and Neighbourhoods program brought additional capacity [an extended workforce and funding] to work in the area.'

(Program Manager, Housing, Co-spokesperson, Community NGO).

Or, in another example, the catalyst was a pre-existing First Aid for Kids education program that would be of benefit to all parents. A collaboration was formed between hospital staff, CGHiC project staff, a refugee community, and Refugee Health. The group modified and translated the First Aid for Kids program into the community language and conducted two one-day education programs for mothers. It was received very positively.

It is noteworthy that a further effort to provide education for the male partners of the refugee community mothers was delayed by a change in personnel in one of the organisations that was party to the collaboration. A new manager did not recognise the need for such a program.

Even collaborations that succeed in achieving one goal may not continue to succeed in achieving another. In some cases, it may be necessary to wait for conditions to change (e.g. for new research or a change in personnel) before it is possible to proceed further.

Individual program champions often play important roles in establishing collaborations. However, program champions may sometimes

commit their organisation to working with others before obtaining formal authorisation from their own organisation, and they may act without authority to commit resources (other than their own time and skill). Without such authorisation or authority, a collaboration is unlikely to succeed.

> *'I do think that pre-existing personal relationships play a big role [in establishing collaborations]. Trust, having a track record, for example. But a disadvantage of that can be a threat to sustainability [e.g. if people leave or priorities change]'*
>
> **(Senior Academic, Service Director, Health).**

Sometimes, stakeholder organisations begin to collaborate on a small scale to demonstrate the potential effectiveness of collaboration and to persuade their sectoral policy makers to invest. In Example 3, health professionals worked with colleagues from other social and welfare sectors to develop an integrated care program for providing a range of health and social services to meet the complex needs of a marginalised community. The successful implementation of the program became a catalyst for health policy changes and increased investment, creating a positive authorising environment and enhanced opportunity for collaboration on a larger scale.

EXAMPLE 3: ARE CATALYSTS OR OPPORTUNITIES AVAILABLE NOW?

The opportunity for organisations or sectors to collaborate can arise as a consequence of new or changed State or Federal Government policy. One example was the NSW Ministry of Health's Integrated Care Strategy.

'The Healthy Homes and Neighbourhoods program in Inner Western Sydney was years in the making. Earlier collaborations had changed or fallen away over time as different sectors changed their priorities, with changes in funding, in the political environment, and structural changes within sectors. Nonetheless, the legacy of earlier collaborations was important in sustaining support for the idea of collaboration across the years when resources and policy support had declined.'

A cross-sectoral collaborative group saw that *'When a new integrated care funding stream created an opportunity for us to use past experience and contemporary knowledge of the needs of families in our area, we were able to develop a successful application for funding. We were well prepared when the opportunity arose.*

'We have learned though, that opportunities for collaboration ebb and flow over time as policy priorities and personnel change within the collaborating organisations. Staying vigilant to identify emerging opportunities is necessary to sustain successful long-term collaboration'

(Program Manager/Clinician, Health).

As resources become scarce, organisations may retreat to the conduct of their core business, and reducing risks associated with new initiatives. On the other hand, organisations in an environment in which resources are scarce or shrinking, may become more interested in collaborating, seeking to enhance the resources available to address a problem or to make best use of limited resources.[2]

What does a collaboration look like?

A COLLABORATION IS a new form of organisation that is created for a specific purpose that cannot be achieved by existing organisations on their own. Each collaboration looks different and is dependent upon the parties that are included, the intended goal and on the capacity, including commitment, that each of the parties brings into the collaboration.[49]

A structure and a form of governance

A COLLABORATION IS comprised of a structure and form of governance, and a network of people who represent different stakeholder organisations. The form any collaboration takes is the outcome of negotiation among their stakeholders.

The goal of a collaboration can be as simple as sharing information in newsletters and websites, or as complex as developing joint protocols, designing new services or products, or developing new policies.

Collaborations formed to achieve simple goals may require only an informal, loosely defined structure (e.g. a committee), and only limited investment of staff time and resources for a defined period. Other collaborations formed to achieve more ambitious, complex goals, may require a more formally constituted

"Each organisation has its own policies, practices, resources and its own performance indicators. These influence the decisions of the people who represent them in collaborations."

"Each person brings their own personality, values, beliefs and professional experience to the work."

structure involving a greater number and more diverse range of parties, and greater investment of time, resources and expertise. In these more complex collaborations, parties need to negotiate more explicitly defined rules and processes and more clearly defined responsibilities for leadership. They also need to commit to investing a greater level of resources for a considerable time. The Tamarack Institute developed a Spectrum Tool [51] that describes different forms taken by collaborative structures.

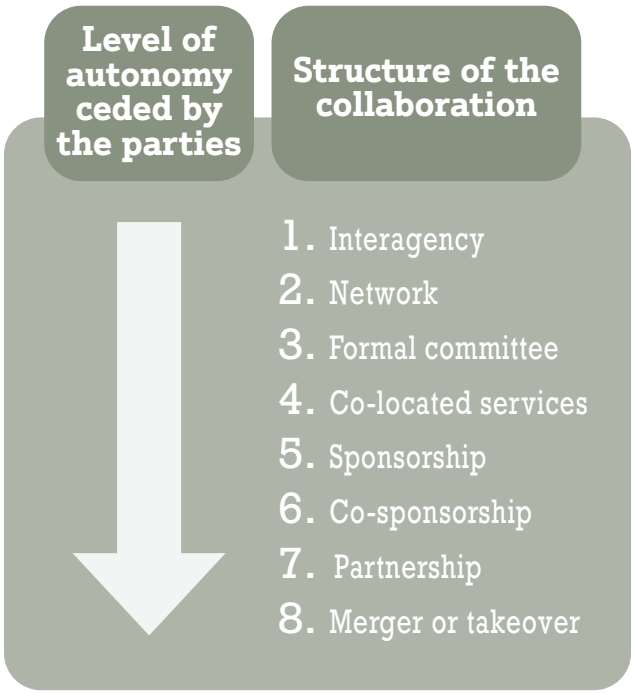
The quotes below describe some of the ways in which structure and governance contribute to effective collaboration.

> *'To do this sort of work you need a structure. The client sees the community NGO as the support, not me. They wouldn't know which health organisation I work for. They wouldn't have a clue. Which works because if I need to take time off, or if something happens or I move jobs, the client still has that structure'*
>
> **(Program Manager/Clinician, Health).**

> *'I would say having the defined structure and governance processes and the jointly prepared plan in place has meant the relationships have been easy to redevelop professionally as people changed'*
>
> **(Program Director, Education).**

No matter how formal or informal the structure, implicit in establishing any collaboration is the agreement of the parties to contribute some of their own capacity and autonomy to a separate entity that has been set up to resolve a particular problem.[50]

Different forms of collaboration structure are listed below in ascending order of the level of autonomy which parties have agreed to cede to the new structure – from the least to the most.



Even when all the parties come from within the same domain or sector, it may take some time to identify the contributions of each to a problem and to potential solutions. In other cases, parties may have already recognised the overlap in their goals and concerns and may be keen to begin.

The Healthy Alliances Framework[49] identified both institutional and personal factors that parties bring when they enter collaborations, and that influence their commitment to collaboration.

'Institutional factors are the circumstances or incentives that are rooted within the policies, practices and resources of each of the organisational parties in a collaboration. The

importance of understanding this is that, in addition to contributing to the achievement of a "collective" goal, each party is also still accountable for its own performance, for meeting its own key performance indicators, and for the efficient, effective use of its own resources'.[49]

The people who have been authorised by their organisations to engage in a collaboration are influenced by these institutional factors. But they also bring their professional and personal attitudes, values and beliefs, their knowledge and skills, and their willingness to contribute to positive, trusting interpersonal relationships with others within the collaboration. These factors tend to 'stick to' the people and, in addition to their institution's norms and policies, they also influence people's contributions to collaborations.[48,49]

Positive, sustainable relationships between both the people and the organisations in a collaboration are necessary to enable them to navigate through their differences. Table 1 illustrates factors that parties consider when deciding on the form a collaboration will take.

Are the structure and governance 'fit for purpose'?

PAYING ATTENTION to establishing a collaboration that is 'fit for purpose' may seem onerous when parties are keen to proceed. However, agreement upon the rules and processes that will be used to decide on leadership, membership, management, agendas and deliberation, and on the rules governing decision-making (consensus or majority rule), establishes transparent governance mechanisms, and this is an important precursor to success. Other characteristics of effective processes have been identified as:

- Organisational representatives are encouraged to disclose their organisations' self-interest in participating in the collaboration;
- Early meetings are focused on building trust and familiarity among the parties;
- Early meetings are focused on creating shared understandings of the problem, its determinants and of each party's views on effective responses;
- Regular meetings are held and decisions are documented carefully and disseminated routinely.

Pre-existing relationships among the organisations and among the people who are engaged can assist as parties decide on the commitment and contributions that each is able and willing to make in establishing and maintaining a collaboration, and on the conduct of its intended work.

However, even when parties are initially satisfied with the structure, governance, resources and work of a collaboration, tensions can arise. Changes in the operating

Table 1 Factors influencing decisions on the form and governance of a collaboration

Formality

- Will the collaboration have:
  - A formally constituted structure that has formally agreed to the rules and process to be used to identify leaders and to manage the collaboration?
  - An informally agreed structure based on transparent negotiation of the parties' roles and responsibilities?
  - A loosely agreed structure that leaves decisions about leadership, rules and processes to continuous negotiation among parties as the collaboration proceeds?

Intensity

- What frequency of meeting is required?
- What are the formal and informal communication channels, both interpersonal and between the collaboration and each of the organisational parties?
- What level of staffing, funding and in-kind resources is required or committed by each party?
- What are the expected contributions and responsibilities of each party?

Duration

- What is the intended 'life' of the collaboration?
- At what point will a review of duration be conducted?

Autonomy

- Has each party agreed to the extent of the autonomy they are willing to share?
- Is there a clear delineation of the overlap of interests and power over decision-making among the parties?

environment, in personnel or in the anticipated benefits or differences in the expectations, values and power of different parties, can lead to conflicts. So too can dissatisfaction with levels of resources committed to collaborations by different parties.[49]

Common indicators of conflict emerging in a collaboration include: parties sending apologies rather than attending meetings; lack of active participation in meetings; reluctance to commit resources; and growing levels of anxiety being expressed about lack of progress.

The following quotes describe circumstances in which tensions arose within a long-standing collaboration in the SLHD.

> *'We were all feeling our way. I felt like sometimes I was treading on eggshells, because we would lose a director [from the other Department] after every four months. There has been a lot of [personnel] turnover'*
> **(Senior Executive, Health).**

> *'I think it has been possible to observe inter-organisational tension as Health and our Department have recently attempted to establish a human services governance group that seemed to double up on the existence of other [similar] groups. Some people in our Department though, were saying "No, no, no, this isn't always Health's show. We've got some priority areas that aren't getting identified so we want to set up a system to have that happen"'*
> **(Program Director, FACS/DCJ).**

It is not uncommon for individuals who encounter difficulties in a collaboration to comment as follows:

> *"No matter how often I told them they were being obstructive and difficult they still wouldn't change their ways", or "We made it clear to them that we saw them as the biggest barriers to change ... even so they wouldn't come to the meetings"*[44]

Such quotes illustrate how useful it is to recognise that, in addition to being individuals, the people who participate in collaborations are not free to contribute only as individuals. They are also representatives of their organisations, and their contributions are shaped by the policies, practices and norms of those organisations. Conflict can arise as a consequence of decisions or positions taken by their organisations that the individual representatives are unable to control. Representation of actors (individuals) alone cannot ensure effective collaboration when they cannot negate the political values and conflict that are embedded in the institutional interests of their organisations.[50]

Are relationships being built and maintained?

IT IS ALSO THE CASE that the day-to-day work of a collaboration is carried out by individuals who bring their own personality, values, beliefs, and professional experience to the work. The establishment and maintenance

of sustained trusting and respectful interpersonal relationships is challenging work, that can distract a collaboration from achieving its intended goals. Conflict can arise as a consequence of individual differences in personality, values or beliefs, as well as differences in views about the focus and work.

Adding complexity to this, individuals may enter the collaboration as organisations restructure or change policy direction, or as people move on in their careers and lives. There is ongoing need to renegotiate the relationships among the people engaged in the day-to-day work.

What a collaboration looks like depends on its purpose and the commitment of its members.

> "Positive, sustainable relationships between both the people and the organisations in a collaboration are necessary to enable them to navigate through their differences."

What capacity does a collaboration need?

A workforce

A WORKFORCE IS REQUIRED that includes a mix of people who bring knowledge and skills to: (i) facilitate the relationships and sustain the collaborative structure; (ii) contribute to joint planning; (iii) conduct and manage the implementation of recommended actions, including allocating and managing resources; and (iv) monitor and report on progress and achievements. A comprehensive range of roles and associated competencies is required by a collaboration's workforce.[52]

Not all collaborations require that the workforce includes people who bring each of the competencies listed in Table 2. However, all collaborations require people who bring the knowledge and skills of boundary spanners; that is, people who have the skills and competencies to understand the interdependencies of the parties and the differences between the parties in collaborations, and to create engaging, respectful and trusting relationships among them.[60,50]

The range of competencies required by the workforce of a collaboration between a health

In brief

THE CAPACITY a collaboration needs is comprised of:

- **a workforce whose members have been authorised by their own organisations to represent them in the collaboration;**
- **a workforce that includes people who are capable of carrying out the maintenance and production functions of a collaboration. Boundary spanners, program champions, technical experts, and skilled facilitators are vital;**
- **resources to maintain and sustain the collaboration;**
- **resources to do the work and to carry out recommended actions.**

“…we could engage people who had a real understanding of the importance of an inter-agency-process and approach…”

service and a university, is described below.

‘Individuals have different goals and skills. When you’re trained as a researcher, you’re not necessarily trained to do community development, and in neither case are you necessarily trained or prepared to do the bureaucratic/administrative/ internal advocacy work within or between organisations. A range of skills, attitudes and knowledge is required to manage both the relationships [within collaborations] and the work itself’

(Senior Academic, Service Director, Health).

Some organisations establish specialist roles to ensure that their representative(s) in the collaboration’s workforce are well prepared to contribute to the collaboration’s maintenance and to the conduct of its work.

‘This Department established positions to support interagency work to support schools and complex students. Having the positions meant that we could engage people who had a real understanding of the importance of an inter-agency-process and approach’

(Program Manager, Education).

Increasingly, communities or social groups are recognised as being essential parties to the resolution of complex health and social problems. However, in order to influence the decisions made by collaborations, communities that have been historically marginalised from full social participation may need support (and time) to organise and identify who will be their representatives in a collaboration and to amass sufficient power to exercise influence in decision-making.[44, 45]

In an example of the need to support a collaboration’s workforce, the quote below explains how changes in the demographic composition of a community over time, led to changes in the capacity of the community’s representatives to participate effectively.

‘The capacity of many of the people in public housing is very different from the capacity of people who lived there twenty years ago. A lot of people then were from working class backgrounds, had experience on the shop floor, in the union movement for example, but now, we’re dealing with a new demographic. People coming into public housing don’t have many of the skills that their predecessors had in working together [even within community organisations]. And on the other side, the resources for doing community development are dwindling, so that building people’s ability to be able to speak up on their own behalf, or to articulate their own issues in a public forum, is also a bit more complex’

(Co-spokesperson, Community NGO).

Table 2 Comprehensive range of roles and competencies required by a collaboration's workforce

Roles	Competencies
Leadership	• A collaborative mindset[49] and a belief that a problem needs to be addressed through collaboration.[61] • Power and authority to commit their organisation to working in partnership and/or to commit resources to facilitate the maintenance and work of the partnership.
Boundary spanning	• Connecting parties by enabling and organising their interaction. • Attending to issues of equity, unequal power and trust building. • Fostering understanding among parties' different interests. • Supporting the creation and maintenance of knowledge networks and communities of practice.[3]
Advocacy	• Public speaking, persuasive and motivational skills. • Ability to use mass and targeted communication media. • Ability to frame issues so that diverse partners can understand the relevance to them. [47, 62, 48, 63, 2, 49]
Group Facilitation	• Psychological competence, group leadership and interpersonal communication skills. • Social skills, group leadership skills, organisational competence and project management skills. • Ability to promote openness, trust, autonomy and respect among organisations and individuals in the partnership.[61]
Champion	• Ability to communicate within their own organisations and with the collaboration to ensure the visibility of the issue that needs to be addressed. • Ability to build and sustain support for working in partnership, for the resources and for the actions taken by the partnership. [64]
Technical / Professional Expertise	• Scientific / technical knowledge on specific issues. • Skills and experience in identifying determinants of complex problems in planning and in implementing effective solutions. • A wide range of technical and professional expertise and experience.

Resources

ALL COLLABORATIONS require access to material resources, including funding and infrastructure support, a meeting space, information technology, and to professional/ technical resources (e.g. a Health Impact Assessment [HIA] or planning template). These are often, readily committed as in-kind resources by participating organisations. However, many collaborations also need stakeholder organisations to contribute funds to sustain the collaboration and to ensure the conduct of the work.

'Our Department wasn't bringing a big bucket of funding or new dollars to the implementation of the Child Health and Wellbeing Plan. We needed to reinvest existing resources or to reorganise our priorities. We needed to debate and discuss internally, to make sure what we could bring to the implementation of the plan'

(Program Director, FACS/DCJ).

'The ongoing organisational commitment [from each of the stakeholders] has carried the ongoing work of the collaboration'

(Senior Manager, Health)

The benefit of combining resources from different organisations, as well as people from diverse cultures and professions, is described in the comment below.

'There is no way that I [as a health professional] could be sat here in the community on my own and do what I do without our close relationship with the other sector. Our work is nothing without collaboration. The families that I work with are so mistrustful of services'

(Clinician, Health).

However, when different levels of resources are invested by different stakeholder organisations in a collaboration, it is common to find high levels of distrust between the parties and low value assigned to the contributions of other parties.

'I would say that even after the [Plan] was launched and when it came to implementation, I think that internal debate and the re-resourcing or shifting of resources has had to continue. We've had to target specific managers within our Department to take the lead on some of the implementation initiatives, and it's been necessary to make sure that our own commitments are met as those managers change.

Although the managers and operational staff have the capability to do the work, finding time to do additional or different work is a challenge from a capacity perspective'

(Program Director, FACS/DCJ).

'The health sector brought new funding into the collaboration, and if we hadn't gotten that, I doubt that we would have been talking about partners and saying "this is a long-term way of working"'

(Senior Executive, Health).

Effective collaboration: an innovative solution, positive organisational relationships and enhanced resources

IN EXAMPLE 4 below, a community organisation identified a gap in routine child and family health care. Three organisations (a community NGO, a private sector organisation and part of the health sector) contributed to the capacity of a collaboration to deliver a child and family health service that was tailored to meet the needs of same-sex parents.

EXAMPLE 4: BUILDING THE CAPACITY OF A COLLABORATION

Rainbow Families, an NGO that had been established to assist and support LGBTQIA [Lesbian, gay, bisexual, transgender, queer and intersex] families, had found that LGBTQIA parents were concerned that mainstream child and family health services were not tailored to meet their particular circumstances and needs. For example,

'... if a lesbian couple went to mainstream classes and part of the teaching required the class to divide by male and female gender, [it was assumed] that one member of each couple would play the role of a male. This could be traumatic for same sex couples.'

'As well, access to post-natal care and education [is] not widely available to LGBTQIA families. An increasing number

of gay dads are adopting babies from overseas but may not be receiving effective postnatal care, including, for example, not knowing where to get a Blue Book from and not having access to all the necessary basic information or care. GPs [General Practitioners] are often great, but it's not uncommon for Rainbow Families to be told by their GP that everything's fine, and to later find that the child has quite significant issues. So it's about educating parents on where to access services.'

(Executive, Community NGO).

The NGO had developed an antenatal education program for their families but wanted to enhance its quality and legitimacy by having it delivered by parent educators from a Child and Family Health Nursing service. They wanted to ensure the program could be delivered routinely, and that it would include opportunities to engage with families postnatally. The NSW Ministry of Health recommended the LHD as the most appropriate provider. A private sector organisation had established a Pride Committee to further the interests of LGBTQIA employees and community members, and selected sponsorship of this program as a priority. It was able to contribute spaces and financial support for the delivery of the program.

The LHD's Child and Family Health Service could provide the educators but could not provide all the specialised resources needed by the parents. The NGO had an established partnership with the private company and agreement was reached between all the parties about the contributions of each to the collaboration to ensure it succeeded.

Reflecting on the experience of working in collaboration, one of the representatives commented

'Working together takes some initial work, an initial effort to understand different ways of thinking among the agencies and people. You sort of have to do that for six months or so of talking and pilot testing, and then it pays off'.

(Senior Manager, Health).

"There is no way that I could be sat here in the community on my own and do what I do without our close relationship with the other sector."

What is the work?

THE WORK OF A COLLABORATION is comprised of maintenance and production functions.[48, 66, 67]

Maintenance function (1): building and sustaining relationships

THE FORMATION and maintenance of positive interpersonal and inter-organisational relationships is vital to the success of collaborations. Such relationships require trust, confidence, respect and inclusiveness.[48]

Building on existing or pre-existing relationships is protective when the parties have a history of trust and confidence in working successfully with one another. The inclusion of new parties, however, requires particular attention to be given to their involvement as equal members with equal power to participate in and influence the decisions of the collaboration. This is of particular significance when the new parties are representatives of previously excluded communities and consumers.

The success of all collaborations depends upon both interpersonal and inter-organisational relationships that are sustained for sufficient time to enable the collaboration to carry out its work and achieve its goals. However, although strong interpersonal relationships are likely to facilitate the establishment and maintenance of collaborations, they are not sufficient on their own to sustain the inter-

In brief

THE WORK of a collaboration is comprised of maintenance and production functions.

Maintenance functions

- **Building and sustaining positive, trusting interpersonal relationships.**
- **Building and sustaining positive, trusting inter-organisational relationships.**
- **Managing conflict.**

Production functions

- **Creating shared meanings among the parties.**
- **Jointly planning actions and agreeing on the responsibilities of each party, including the resources to be invested.**
- **Establishing a structure and process to oversee the implementation of actions.**

organisational relationships that are also vital to the success of collaborations.

Conflict can arise from political or ideological differences among the parties. Understanding that conflict within collaborations may be the result of underlying interests and power relations between parties can be helpful in identifying mechanisms to facilitate cohesion and enable joint action.[50]

The quotes below illustrate on the one hand, the importance of interpersonal relationships, and on the other hand, the significance of inter-organisational relationships.

'Interestingly, some of the external agencies who've worked on collaboration with health systems said that continuity [of the people engaged from] within the LHD has really fostered the collaboration'

(Senior Manager, Health).

'Some individuals were really well connected and have collaborated for many years prior to this plan, and that meant that coming together and forming a collective ethic and ethos around what was trying to be achieved was an easy piece of work. It wasn't anything that needed to be debated, it wasn't lots of professional tensions, it was just because of the layer of history to these groups of people'

(Program Director, FACS/DCJ).

'For me, the challenge in collaborating between the LHD, the university and the PHN, is that it is so highly dependent upon relationships. Although we have MOUs [memoranda of understanding] in place, they're not sufficient. You have to have positive interpersonal relationships and trust'

(Senior Academic, Service Director, Health).

'I think it's easier to maintain a relationship between different parts of the health sector if you're working on a project as part of a team. It's harder to sustain relationships between organisational representatives from higher levels within their own organisations. We need to collaborate at all levels, at management and accountability levels and at project levels, to remain valid, appreciated and relevant'

(Senior Academic, Service Director, Health).

Establishing and sustaining the interpersonal relationships among the people involved can be complex. The people who are engaged in the collaboration are there as representatives of their organisations, and their contributions to the relationship are influenced by their organisation's goals, policies and norms. However, the people are also individuals whose personal characteristics, professional training and experiences, worldviews and pre-existing relationships affect the interpersonal relationships within the collaboration.

Maintenance function (2): managing conflict

THERE ARE PREDICTABLE stages in the evolution of interpersonal relationships within groups, those stages being described as forming, norming, storming and performing (goal attainment or renewal). Skilful facilitation to navigate through such stages is needed to sustain relationships for sufficient time to enable a collaboration to achieve its intended goal.

'When someone was difficult you'd go, "Okay, this person's got a point of view and I'm really prepared to listen to it because she has some really useful contributions". There were, however, times where conflict arose and you would have to back up your own people, pointing out that "The people here are senior people in our organisation, who are correct in what they are saying. I would agree that it is important to discuss differences in views about policy before making decisions, but the differences can't be just because personalities were clashing, and there were strong personalities, weren't there?"'

(Senior Executive, Health).

Conflict can also arise as a consequence of differences in the interests, values and power of the parties.[67] It can be challenging to see and address such differences. Boundary spanners have important roles in identifying these and in leading action to resolve them.

Production function (1): creating shared meanings

ALTHOUGH health sectors everywhere have long identified social determinants of health that are generated by decisions and actions of sectors other than health, many other sectors (and organisations and people within them) are not well informed about their contributions to health or illness and injury. It is equally true that the health sector is not necessarily well informed about the core business of other sectors, their political and policy contexts and their ways of working.

Evidence is also growing of unconscious biases that are embedded in the structures, policies and norms of professions and organisations, and in their representatives.[56] Although often invisible to people from dominant cultural groups, such biases are increasingly recognised as contributing to the inequities in health experienced by marginalised social groups.[34, 40]

Recognising and understanding such factors is a vital part of the process of working across sectoral, organisational, professional, cultural and personal boundaries to create shared meanings, and to negotiate effective, efficient ways to work together to bring about positive outcomes.

Successful collaborations begin with sharing information and experiences among the parties. The purpose is to create shared meanings that enhance knowledge and understanding of the relationship of each of the parties to the problem or solution and to its determinants. This is necessary both to enable a collaboration to reach shared goals and to decide on the contributions that each of the parties can and will make to resolving the problem.

'What was really significant was the development of understanding between the people who worked for different agencies, making sure that we were planning as a collective group that had a connection to the deliverables throughout the agencies and making sure that the plan (developed collectively) connected to individual agencies' goals and management; [asking] how does it fit with existing strategic plans?'

(Program Manager, Education).

A growing range of methods and tools is available to assist in developing shared meanings among diverse parties about complex social problems and their determinants, and about evidence-informed solutions. Recognising that biases embedded in the structures and policies of organisations, and in the ways of thinking and decision-making of health professionals, is resulting in actions to bring about positive changes in individuals' and groups' ways of thinking, as well as in the organisation and delivery of culturally-led health care services,[33] and in the engagement of marginalised communities in collective decision-making.[45]

Methods and tools developed by the health sector to facilitate inter-sectoral policy analysis, planning and practice include:

Health Impact Assessment (HIA) and Equity-Focused Health Impact Assessment (EFHIA)

HIA and EFHIA are methods used to guide evidence-informed assessments of the potential health and equity impacts of proposed plans, projects or policies on a population, and of the distribution of those impacts. An analysis of the evidence is then reviewed to identify potential modifications to mitigate risks to health or to enhance positive impacts on health and/or health equity. Both HIA and EFHIA are also processes, that, as far as possible, bring together all relevant parties, including affected communities, to collaborate in gathering and analysing the evidence, in deciding on the impacts on health, and in recommending modifications to the proposal being considered. HIA and EFHIA can be initiated from within the health sector or by external agencies or groups.

Other forms of impact assessment have been developed using similar methods and processes including, for example, Aboriginal Health Impact Assessment, Mental Health Impact Assessment, Environmental Impact Assessment and Social Impact Assessment.

Health in All Policies (HiAP)

HiAP is a collaborative way of working that seeks to improve the accountability of policymakers for the health impacts of policies made by all sectors, and at all levels of policy-making.[81] The goal is for the health sector to collaborate with agencies across government to better achieve public policy that contributes to positive population health and wellbeing outcomes. Based on systems theory and employing a collaborative process, HiAP uses a health lens to identify and clarify evidence of predicted impacts of a potential policy decision on health, and to negotiate agreed modifications to increase health and

other social benefits. The incentive for other sectors to work in synergy with health is that the health sector's reputation, resources, and power can add evidence and legitimacy to the proposed policy and can assist in the adoption of policy proposals by other sectors.[82]

Healthy Settings

A HEALTHY SETTING Is a place or social context in which people engage in daily activities in which environmental, organisational, and personal factors interact to affect health and wellbeing. Settings have physical boundaries, bring together a range of people with diverse roles, and they have an organisational structure.

Within settings, it is possible to take multiple actions to contribute to the health and wellbeing of the people in a given setting – including, for example, changes to the physical environment, and/or to an organisation's policies or service delivery. Settings are also places in which people's health can be enhanced through programs that reach people directly.

Healthy Settings approaches have been implemented in a variety of sectors including Healthy Cities; Health Promoting Schools; Healthy Workplaces; Healthy Islands; Health Promoting Hospitals; Health Promoting Prisons and Health Promoting Universities.[84] Several tools are available to assist in assessing the quality of collaborations for health in such settings.[85,86]

Production function (2): planning jointly

TO ACHIEVE their goals, the work of some collaborations is limited to exchanges of information among parties. However in other cases, the work is more complex; for example, resolving a problem that has multiple determinants or that requires multiple parties to respond to a crisis, or changing public policy or redesigning services or products. In such cases, the parties need to work jointly to identify what actions are needed to resolve the issue. That process requires not only sharing information and analysing evidence, but also negotiation to develop a joint plan of action, and to agree on the responsibilities of each party and on the resources they will commit.

Planning jointly can expose differences in perspectives on the causes of problems and on available solutions. Skilful navigation and management are required to reach an agreed plan of action. Although, ideally, the plan should include measurable objectives and outcomes, in practice, collaborations often adopt a pragmatic approach to joint planning so as to accommodate the differences in method, skill and resources available to the different parties involved.

'We didn't always follow the technical approaches [to collaboration]. We just had something that we all shared and a vision of getting a child health plan going. That was more of the thing that drove us and kept us together, I think. And having a timeframe,

knowing that this was probably going to be a first for the metro, and virtually for the state, in actually getting this done'

(Senior Executive, Health).

'It was a good process overall. It felt a bit long-winded at times. There were some personality clashes and some people saw themselves as specialists in this and a few got offside. Other groups were also involved in parallel processes and there was some confusion, even among health professionals, about why they would engage in this. However, as the meetings continued, I think the relationships changed a little because [we were] no longer trying to see each other's business as being different, but trying instead, to see what overlapped, or where the gaps were and how we could work together. It was a real change then. We had the Child Health and Wellbeing Plan to work together on'

(Senior Executive, Health).

EXAMPLE 5: A BALANCE BETWEEN MAINTENANCE AND PRODUCTION FUNCTIONS IS ESSENTIAL

'A local health district and a state-based office of our department, recognised that collaboration could increase the efficiency and effectiveness of services and strategies to increase child health and wellbeing.To do this, the IWIPPG was formed.'

'It was decided to prepare a joint plan for Child Health and Wellbeing. The joint planning was complicated. We had to make a lot of changes to get it into a state of clear actions for each of the stakeholder agencies to take on board.

'From the perspective of the Department [not Health], we had two key functions that related to the child cohort. From a child protection perspective, our role was to respond to children assessed as being at risk of significant harm, and in those responses, developing pathways for families to resolve any child risk issues. Second, another part of the role [of our sector] was to build the funded services sector to enable us to deliver joined-up services for children and families that included intervention programs.

'Relationships are always a critical part of successful collaboration. Informally, I think the relationship was negotiated through the Chief Executive of Health and the FACS lead. And the other level has been good relationships between the health team and the FACS team at operational and planning levels. Some individuals were particularly well connected.

'Having the infrastructure of the Child Health and Wellbeing Plan and the governance around the plan in place, has meant that in an environment in which there have been constant changes in structure and senior executives, the relationships have been easy to redevelop professionally'

(Program Director, FACS/DCJ).

What actions are carried out?

PLANNING JOINTLY and agreeing to take responsibility for the implementation of recommended actions are necessary steps toward achieving the goals of a collaboration. Having decided on the actions that need to be (and can be) taken by the parties in a collaboration, the next step is to mobilise the parties' commitment and resources to act.

Implementation is more likely when recommended actions are simple. For example, conveying information emerging from an interagency meeting back to each of the parties. Implementation is less likely when recommended actions require the investment of a significant level of new resources, including time; or when they involve making a complex change in policy or in usual practice (core business) of one or more parties; or when they present a challenge to the usual way of working or to the reputation of any of the parties.

'We need to be flexible [to work effectively in collaboration], and rigid models of intake and stuff are not flexible. An initial experience of working collaboratively on a very complex case, revealed the need for flexibility. The initial health sector model had to take a sideways turn because we realised that we needed to respond to families' immediate needs and not to start with having the referral form completed before we could act'

(Clinician, Health).

In brief

FOLLOWING the development of a joint plan it is necessary to ensure that the recommended actions are implemented. That requires that collaborations give attention to:

- **recognising that some of the actions may be simple and can be completed in a short time, while others may be complex and require ongoing commitment from parties;**
- **articulating the roles and responsibilities of each of the parties in the implementation of recommended actions – recognising that some actions require the active contribution of several parties, and that others may need action from only a single party;**
- **ensuring that parties have allocated resources to enable and support the actions to be taken.**

In addition, collaborations need to establish a recognised mechanism to oversee and monitor implementation, to review progress, and to resolve problems.

Implementation of some planned actions may require several parties to act jointly – in advocating for public policy change, for example. Implementation of other actions – such as changes in the delivery of a specialist service, may be the responsibility of a single party.

Some collaborative actions may be ongoing. For example, parties from the housing and health sectors decided to co-locate staff in a local community, enabling them to build trusting interpersonal and professional relationships and to deliver services routinely to meet clients' needs effectively and efficiently.

'Because of our linkage between the two agencies, we can ensure that clients receive the services necessary to keep them safer and healthier at home [e.g. by organising for support services, domestic cleaning, Webster medication packs or podiatry]. Working together, the two sectors are able to ensure access to social determinants of our clients' health and safety; housing, transport, nutrition, access to GPs and appropriate medication. Conversely, the other sector's role in managing clients' housing needs is more efficient and effective when their clients are receiving high quality health care. Together we can undertake personalised education to support clients to self-manage their chronic conditions, and to ensure safe, appropriate housing. We have significantly improved communication between health and housing professionals and have achieved some very good outcomes'

(Senior Clinician, Health).

Joined up planning does not always translate readily into 'joined up implementation', even when there is understanding and goodwill. The intention to act jointly may not be readily achievable when there are differences in the capacity of the parties.

'I think that whole idea of having strategies we could work on together, rather than things that were related to one particular agency, was very good. It was always [though] a struggle for me when I was working on it, to find people I could pass it on to [in my own organisation] to actually do the work. There was a little bit of resistance because it wasn't physically part of anyone's job. But we managed'

(Senior Manager, PHN).

Working together jointly can require careful management of conflict.

'Working together on a joint project, bits of it worked well and bits of it didn't. All of the logistics management of trying to do quite a significant event within existing resources. It's not like we've got an extra set of hands to help us do all the detail of event management. So it was very challenging and there were some rocky times. But we just worked through it because that's what you need to do, i.e. work through all the issues. And at the end of the day, we're doing it a bit differently this year'

(Senior Manager, Health).

Collaborative oversight helps to ensure that parties report on and review progress, identify and resolve problems, establish that resources are available and provide on-going support to the parties taking action, for example:

'While there was a lead agency responsible for each action [identified in the Child Health and Wellbeing Plan], none of the actions were purely the responsibility of one agency. All the actions had an interagency focus'

(Program Manager, Education).

'Five of us formed the Implementation Committee, and we set up a process that really supported the collaborative nature of the projects that were done. All the high priority projects had to be scoped. They had to complete a scoping paper and while there was a lead, it actually had to be developed in collaboration and they actually had to analyse the collaboration and any of the risks and what type of collaboration it was. We sent out documents so that people could really think about how they were working together in doing the work and what that would mean, so that it didn't just become something that just one organisation did. And then they all came back to the Implementation Committee where we reviewed them. If we didn't think they were collaborative enough, or they weren't really involving partners, or they couldn't evidence it, we didn't accept it. It went back and we set up processes to ensure that was how the work was done'

(Program Director, Health).

The quote below illustrates how collaborative actions can create unexpected opportunities for further changes to improve health and wellbeing in a community.

'The majority of things are progressing well. And the interesting thing that I think has come out of it, is that we had these projects and they've done a whole lot of work and although we've had some reports against the [collaboration], we were actually aware of a whole lot of other things that happened because of the collaborations between different groups that have still fitted into these initiatives'

(Program Director, Health).

"Collaborative oversight helps to ensure that parties report on and review progress, identify and resolve problems, establish that resources are available and provide on-going support to the parties taking action."

In brief

1. Measurable goals and objectives enable measurement of the extent to which the impact and outcomes of the work carried out by collaborations can be assessed.

2. Evaluation design needs to be 'fit for purpose' and to have adequate resourcing. The evaluation design may need to account for the fact that large, ambitious projects to improve population health outcomes and/or reduce inequities in health, might need many years for impacts and outcomes to be realised.

3. In addition to evaluating the impact and outcomes of a collaboration's work, each of the parties is accountable for the contribution of a collaboration's work to their own core business. Ensure that the evaluation design includes indicators of success that are relevant to individual parties.

Did it work?

Monitoring the quality of collaboration

INDICATORS of the quality of a collaboration are the continued willingness (or not) of the people in the workforce to participate, and the continued willingness of the organisations they represent to continue to support and invest in sustaining the collaboration.

For individual members of the workforce, their sense of autonomy, of competence, communication and trust, and of their power to influence the decisions of the collaboration are indicators of the likelihood of their continuing to participate in a collaboration.[3] In addition, indicators that organisations are committed to ongoing participation are ongoing expressions of support, regular attendance at meetings, and the continued investment of resources in maintaining the collaboration and in carrying out its work. [87, 88]

However, as necessary as it is to sustain a collaboration, it is only one measure of success. It is equally necessary to evaluate what a collaboration does and what effects on health (or on one or more of its determinants) the actions produce.

Process evaluation: is the collaboration fulfilling its production functions?

PROCESS EVALUATION assesses whether a collaboration has, in practice, undertaken the work that it was established to carry out. Has a joint plan of

action been developed? Does the plan identify recommended actions and their intended objectives? Has the logic of the relationship between the actions and their intended objectives been delineated? Have parties committed to implement the actions? [89 90]

'We're doing the partnership evaluation and the plan stands as the formal, signed off evidence of success'

(Senior Executive, Health).

Process evaluation also assesses which of the recommended actions has been implemented. It is not unusual for only some of the recommended actions to have been implemented, so that the intended cumulative impact of actions taken by a collaboration is more limited than a joint plan had intended.

Impact and outcome evaluation

COLLABORATIONS are established to bring together all (or most) of the parties that have a stake in resolving complex health (and other social) problems that have multiple determinants. The parties work together to understand the range of determinants of a problem and to identify effective responses or solutions. The parties, including affected populations and communities, then develop objectives and the multiple actions to be implemented (and by which party or parties) often over time to reach the intended outcome or goal.

Impact evaluation

IMPACT EVALUATION assesses the extent to which each of the actions has achieved its intended objective – e.g. improved health literacy, or modified health service delivery, or the safety of a children's play area.

Impact evaluation can also sometimes reveal unanticipated effects of actions taken by collaborations.

'It's interesting the different things we get out of these collaborations. Certainly, I found the whole process really quite valuable in the relationships we made with all that group. It builds attraction to other areas of work. Positive relationships [between the agencies] made our own work easier'

(Senior Manager, Health).

'Other benefits are the opportunities created for the future. The conversation didn't stop when the Child Health and Wellbeing Plan had been developed. We've gone on to talk about youth and other issues, domestic violence, drug and alcohol, suicide prevention, for example. There have been lots of other little secondary conversations that have again come about through this partnership approach. So there has been all these benefits I would say'

(Program Director, FACS/DCJ).

'There are achievements that relate to the relationship between multiple agencies, Primary Health Network, Education, NGOs. So what has come about is a secondary layer of effectiveness, the development of professional networks to resolve day-to-day issues [beyond those addressed in the Child Health and Wellbeing Plan and its implementation]'

(Program Director, FACS/DCJ).

Outcome evaluation

OUTCOME EVALUATION MEASURES the cumulative impact of actions on the intended goals of collaborations. However, it is challenging to identify and measure health (and other social) outcomes attributable to an intervention that is comprised of multiple actions initiated by a collaboration. Many collaborations have insufficient capacity to bring together the technical expertise, resources and time necessary to conduct an outcome evaluation. There are some examples to draw on, using differing methodologies to assess outcomes.[91, 92] Strengthening the evidence of health outcomes resulting from collaborative initiatives is a continuing need.

Even identifying shared outcome indicators can be challenging for collaborations.

'I do struggle with the evaluation, and obviously we keep saying what we would like is a couple of shared outcomes. But there is no real shared thing that each agency has said is a shared outcome that we'd like to see for the community by 2020 and measure it'

(Program Director, Housing).

However, on a small scale there have been some examples of evaluations that can be used as models, demonstrating that it has been possible to measure 'shared' outcomes.

'What the current evaluation is will be shared because it will also be supported by a lot of case studies which will bring out the complexity. For example, there are a couple of families that are very complex, that had their health needs, their housing needs, their legal needs, etc, all serviced by our agency. So that evaluation will then cut across all the agencies.'

(Program Director, Housing).

Ensuring that individual parties are accountable for their own roles and achievements

WORKING ACROSS SECTORS can make accountability lines highly ambiguous and, arguably, complex.[50] Organisational parties to a collaboration are seeking to achieve both a shared goal and benefits for their own core business, including benefits that at the least justify the costs and risks of participating in the collaboration. Benefits being sought may be intangible, e.g. enhanced reputation or protection against loss of power or resources, or they may be tangible, e.g. a positive policy change, an improvement in client satisfaction, or an improved health outcome. Has the investment of resources been 'worth it'? Has the secession of autonomy been acceptable? Has the risk to reputation been acceptable?

'I think that we have to "walk the line" between different perspectives of the organisations, community and people involved, their priorities and perspectives'

(Senior Manager, Population Health).

'Managing the accountability requirements of different stakeholder organisations can be demanding, including the effort required to sustain the relationships and to respond, as required, to reporting needs'

(Senior Academic, Service Director, Health).

'I do think at some points we were probably delivering a few more tangible things in the project than maybe we are now. I think it's now taking longer to do things'

(Senior Manager, PHN).

'I've tried so many attempts at this one [evaluating jointly] because ideally, at the outset we would have had a set of simple shared outcomes determined [and] then measured those along the way. But we never got to that point. In practice, each of the agencies [that were involved] are almost operating under their own evaluations. The parties in a health justice partnership are doing a whole bunch of evaluation. We do place plans with another Department as part of the funding'

(Program Director, Housing).

Understanding and, as far as possible, measuring and reporting on the benefits for which each party is accountable, may be critical to sustaining a collaboration long enough for it to also achieve its shared goal.

> "The parties work together to understand the range of determinants of a problem and to identify effective responses or solutions."

Are the outcomes sustainable?

In brief

SUSTAINING POSITIVE OUTCOMES of collaborative action requires:

- **the inclusion of indicators of the impacts and outcomes of changes in policies, environments, of services, or the delivery of services (for example) in routine data collection and reporting conducted by the health system;**
- **regular review of the data to identify whether it is necessary (and possible) to take action to sustain positive changes.**

SUSTAINING POSITIVE OUTCOMES of collaborative action is likely to require the organisations and people (the parties) who have been engaged in the collaboration to monitor whether initial effectiveness has been sustained over time, and to review what further actions might be needed, and by whom. This may require a review of the membership of a collaboration, a review of the collaborative structure, leadership and governance, and/or a review of the collaborative capacity (including the relationships). Or it may require a return to joint planning to determine if other actions are necessary to resolve the complex problems that led to the establishment of the collaboration.

However, it may also be necessary to identify tensions within participating organisations, often because of time needed to achieve tangible outcomes, to create collaborative relationships and to conduct joint planning and action.

That there is a need to pay attention to sustainability is agreed. However, there is limited evidence of what actions are needed to sustain the impact or outcomes of collaborations. There are likely to be impacts and outcomes that are different for each of the parties – reflecting the different contributions of each to different determinants of a complex health problem, and the different actions that are taken by each as part of the collective actions of a collaboration.

> *'The collaboration should be ongoing, but I feel we need to stay focused on outcomes and not just meetings for meetings' sake. We need to be clear around what our objectives are and have some planned outcomes'*
>
> (Program Director, FACS/DCJ).

Equally, it may or may not be necessary to sustain the collaboration in order to sustain the impacts and outcomes.

Conclusions

COLLABORATION (between the health and other sectors, between organisations and professional groups within the health sector and between sectors, organisations and communities) is one of the essential strategies available to the health sector to improve health and health equity within and between populations.

Many of the complex health problems that are facing countries and peoples today cannot be resolved by health sectors and systems working alone. We have growing evidence of the emergence and persistence of many health and social problems, including inequities in health, increasing threats of infectious disease outbreaks and the health impacts of climate change, to name a few. We have evidence of the determinants of many of the more proximal causes of what are termed, behavioural risks to health, for example, obesity and limited physical activity. But there is much more limited evidence of the full range of determinants of other complex social problems, such as suicide, domestic violence, racism, or sexual violence against women. Although the health sector can describe such problems and increasingly, many of their determinants, the evidence is clear that a significant proportion of their causal origins

“Many of the complex health problems that are facing countries and peoples today cannot be resolved by health sectors and systems working alone.”

lies in decisions made by organisations and people from beyond the health sector.

Collaborations are essential to resolving such problems. There is evidence that collaborations can and do work. But there is also evidence that collaborations often falter and fail. To succeed, collaborations need to balance their focus on maintenance and production functions. They need to survive as an organisational entity, to be governed sufficiently well to maintain trusting, positive inter-organisational and interpersonal relationships, and they need to implement the production functions that have been identified by the collaboration. They also need to evaluate their progress and impact, at least,

and when they are able to amass the technical expertise, resources, and time, they need to conduct outcome evaluation.

The rationale for preparing this Guide is based on evidence that working together across sectoral, organisational, interpersonal, cultural and disciplinary boundaries to improve, protect or promote health can be more complicated than it seems at first glance. The Guide is based on the premise that identifying the core elements of a collaboration, understanding the role played by each party in establishing or maintaining a collaboration, and in carrying out its intended work, can enhance the likelihood of sustained success. The questions in the framework focus attention on core elements that have central roles in determining that success.

> "Organisations and people collaborate to achieve a goal … that any one of the parties working on its own would find impossible or unlikely, to achieve."

1. **Why collaborate?**
2. **Why now?**
3. **What does a collaboration look like?**
4. **What capacity does a collaboration need?**
5. **What is the work?**
6. **What actions are carried out?**
7. **Did it work?**
8. **Are the outcomes sustainable?**

Organisations and people collaborate to achieve a goal (or goals) that any one of the parties working on its own would find impossible or unlikely, to achieve. Therein lies the necessity for collaboration and its promise. Only by collaborating across sectors and between organisations within the health sector, will it be possible to resolve some of the major, complex social and health problems of our time. The growing evidence and experience of collaboration that is outlined in this Guide offers guidance and encouragement for more ambitious undertakings by the health and other social sectors to exert greater influence in creating social, economic, cultural, and physical environments that determine the health and health equity of people in all communities, societies, and nations.

Appendix

Four case studies of collaborations in practice

CASE STUDY 1 The Healthy Homes and Neighbourhoods (HHAN) Program

After five years of implementation, the following enablers were identified as important to the success of the program

The COLLABORATION FOR HEALTH FRAMEWORK	THE HEALTHY HOMES AND NEIGHBOURHOODS INTEGRATED CARE PROGRAM
Background	Health and social agencies had long worked in marginalised communities and recognised the need for a new way of working to overcome long-standing complex health and social needs.
Why collaborate?	To develop an integrated service system that could support families and provide health and social services that acknowledged the social determinants of health.
Why now?	Funding for integrated care became available through the NSW Ministry of Health. Agencies had worked together in the same community for some time and recognised that problems could not be resolved by one agency working alone.
What does the collaboration look like?	The Healthy Homes and Neighbourhoods Multi-agency Steering Committee was comprised of representatives from all relevant health and social services agencies.

The COLLABORATION FOR HEALTH FRAMEWORK	THE HEALTHY HOMES AND NEIGHBOURHOODS INTEGRATED CARE PROGRAM
What capacity does the collaboration need?	Skilled, experienced and passionate staff who had been authorised by their organisations to work in the collaboration. Resources – money and infrastructure. Ongoing support for Integrated Care initiatives from the NSW Ministry of Health and from the agencies engaged in the HHAN Steering Committee.
What is the work?	The work was comprised of maintenance functions (relationships) and production functions. The maintenance functions included building and sustaining relationships through: a) a strong stakeholder engagement strategy; b) regular review of the strategy in action to sustain trust and rapport with parties; and c) communicating routinely with the communities. The production functions included the preparation and implementation of joint plans of action and the routine monitoring of implementation. It meant working at multiple levels at the same time (i.e. patient, professional, service and system levels).
What actions are carried out?	Maximising opportunities for partnership, shared learning and knowledge transfer through shared case work. Each agency contributed as planned.

The COLLABORATION FOR HEALTH FRAMEWORK

THE HEALTHY HOMES AND NEIGHBOURHOODS INTEGRATED CARE PROGRAM

DID IT WORK?

For the health care system

NSW-wide health record data-linkage for adult and child family members enrolled in HHAN care coordination, has demonstrated a reduction in probable preventable hospitalisation, emergency department visits, hospital admissions and length of stay.

For families

Through work with the HHAN team, families are:
(i) demonstrating increased engagement in care;
(ii) experiencing increased feelings of empowerment and a positive perspective of their situation;
(iii) setting long term goals;
(iv) linked to a GP; and
(v) increasing their knowledge of health norms.

Analysis of Patient Reported Outcome Measures indicate that enrolled families are showing a reduction in their conceptualisation of depressive, anxiety and stress symptoms, and an improved quality of life after receiving HHAN care coordination for a period of time.

For the health and social care providers

Qualitative research with health and social care providers has found that the initiative has resulted in more timely referrals between services, helped to foster increased trust between service providers, and has increased knowledge transfer between services.

The COLLABORATION FOR HEALTH FRAMEWORK

THE HEALTHY HOMES AND NEIGHBOURHOODS INTEGRATED CARE PROGRAM

DID IT WORK?

Are the outcomes sustainable?

The HHAN initiative has been identified by NSW Health as a sustainable and scalable integrated care initiative and has been offered to all NSW LHDs and Specialty Health Networks for implementation from 2019.

CASE STUDY 2 Contributing to Strengthening the Power of a Community Organisation – The Rohingya Little Local Project

Case Study 2 describes a practical example of collaboration with a community in which not only information, but power over decisions (including money) was shared between the health sector and an emerging immigrant community.

The COLLABORATION FOR HEALTH FRAMEWORK	THE ROHINGYA LITTLE LOCAL PROJECT
Why collaborate?	In 2014 evidence had shown that the culturally diverse population of one LGA had more limited access to primary health care and was more socioeconomically disadvantaged than the populations of all the other LGAs within the SLHD. That LGA was (then) Canterbury. In 2016, the LGA was amalgamated with another to become Canterbury-Bankstown LGA, meaning that part of the LGA now fell outside the boundaries of the SLHD. The Central and Eastern Sydney PHN the SLHD and the UNSW Centre for Primary Health Care and Equity formed a collaboration that aimed to (i) establish equitable access to primary health care in Canterbury, and (ii) to develop a community-led intervention to overcome at least one socially determined barrier to health. The Rohingyan community was identified as a priority because members had low levels of access to primary health care, high levels of health need (particularly among children), and high levels of distrust of government agencies based on their pre-migration experiences.

The COLLABORATION FOR HEALTH FRAMEWORK	THE ROHINGYA LITTLE LOCAL PROJECT
Why now?	Health system reforms had given rise to new organisations (PHNs) within the sector. PHNs had a mandate to provide primary health care to populations. The SLHD and UNSW had established a new unit (HERDU) that was responsible for supporting the health system to contribute to reducing inequities in health. It was agreed to establish a collaborative project, Can Get Health in Canterbury (CGHiC), to take action to reduce inequities in health in the Canterbury LGA.
What does the collaboration look like?	One of the early actions was to establish an informal collaboration between CGHiC and the Rohingyan community, and build positive interpersonal relationships between CGHiC staff and representatives of the Rohingyan community. Over time, an informally structured joint organising group was established to identify Rohingyan community needs (felt needs), and to identify actions to meet those needs.
What capacity is needed?	The workforce was comprised of CGHiC representatives and members of the Rohingyan community. The CGHiC gathered evidence about what actions can facilitate effective engagement between a health service and a local community to improve health. The CGHiC provided funding, meeting venues and organisational support/skills to the collaboration. The Rohingyan community representatives provided their time, their community organising, professional and cultural expertise, and ready access to their organisational and communication networks.

The COLLABORATION FOR HEALTH FRAMEWORK	THE ROHINGYA LITTLE LOCAL PROJECT
What is the work?	Early efforts by the CGHiC to collaborate effectively with the Rohingyan community were found to be only community informed. The Rohingyan community had not been included in the CGHiC collaboration as a full party and had not been able to advocate for the community members' priorities for health care, or to influence the allocation of CGHiC resources. It was decided to trial a new initiative intended to shift power over decision-making to the community itself.
What actions are carried out?	Loosely based on the Big Local program in the UK, the CGHiC established the 'Little Local' program and allocated $5,000 directly to the local Burmese Rohingyan Communities Association to spend according to the members' priorities. They chose to organise a soccer competition that included Rohingyan participants from three States, and to hold a community picnic.
Did it work? Impact evaluation	The participants reported the impact of these events on their health. The impacts included the exchange of information, the formation of interpersonal and inter-organisational networks and the enjoyment of social interaction and physical activity. In addition, local businesses and community leaders contributed additional resources and support, adding weight to the impact of this community-led initiative. The Rohingyan community judged the initiative to be a great success. As one community representative commented' "It may be the Little Local to you, but it is the Big Local to us."

The COLLABORATION FOR HEALTH FRAMEWORK	THE ROHINGYA LITTLE LOCAL PROJECT
Did it work? Accountability to each party	However, among the four founding parties in the CGHiC, the shift in power over decision-making was considered to be a risk. They saw that collaborating with the Rohingyan community in this way involved them in a process that fell outside their usual ways of working, that did not have predetermined outcomes and that confined health sector staff to roles as observers rather than actors. There were concerns about whether the decision-making processes were transparent, whether they were adequately documented, whether the funds had been allocated legally and appropriately and whether the expenditure and health outcomes would be reported on once the project finished.
Are the outcomes sustainable?	The concerns expressed by some of the parties were predictable, given that each party has its own organisational goals and seeks to protect its own resources and reputation. In this case, the level of concern on the part of a major health sector party was high enough to mean that the CGHiC collaboration (among parties from within the health sector) was dissolved after five years.

CASE STUDY 3

A Comparison of Two Collaborations -
The Children's Services Health and Safety Committee and Access to Children's Services

In this example, although the parties to each collaboration were the same, analysis using the conceptual framework showed that there were significant differences in the conditions under which each collaboration was established; and as a consequence, there were significant differences in what was achieved. The Children's Services Health and Safety Committee was able to establish and achieve a shared goal, while the group seeking to improve access to Children's Services was not.

THE CHILDREN'S SERVICES HEALTH AND SAFETY COMMITTEE

Background

Following an outbreak of measles, the Health and Safety Committee was formed to improve health and safety policies and practices in childcare centres. Major service providers, unions, training bodies, public health units and academics worked together effectively.

Why collaborate?

It was clear at all levels of the childcare and health sectors that they needed to work together to improve policies and practices.

ACCESS TO CHILDREN'S SERVICES COMMITTEE

Background

The same core group of people and organisations that successfully established the Health and Safety Committee had much more difficulty in improving access to children's services for children whose parents were on low incomes or were not in the workforce.

Why collaborate?

There was not a high level of concern in either the health or childcare sectors about the inequitable access to childcare, and it was not clear why or how the sectors could work together to achieve the goal of improved access.

THE CHILDREN'S SERVICES HEALTH AND SAFETY COMMITTEE

Why now?

A dramatic increase in the number of children in care and a growing concern for children's health and safety, created a positive authorising environment for sectors and people to work together. An infectious disease outbreak and growing epidemiological evidence of the risks associated with children being in care, were additional catalysts for action.

ACCESS TO CHILDREN'S SERVICES COMMITTEE

Why now?

Community concerns about childcare were focused on the needs of working parents for childcare. There were no catalysts for action to improve the access of low-income families or of people who were not in the workforce, and there were no policy supports. There was limited data on the nature and extent of the problem and no new ways of thinking among people or organisations that could initiate action.

What did the collaboration look like?

Structure and governance

A committee was established comprised of members who had the authority and support of their sectors.

A shared goal had been negotiated and clarified in a research grant that stipulated leadership and the expected duration of the collaboration.

Structure and governance

There was no pre-existing structure that had the capacity to collaborate and take action on this problem.

Relationships

Most of the organisations involved had worked together before in some way.

Relationships

Different relationships were needed with different parties that had a stake in resolving this complex problem.

THE CHILDREN'S SERVICES HEALTH AND SAFETY COMMITTEE	ACCESS TO CHILDREN'S SERVICES COMMITTEE
What capacity was needed?	
Workforce and resources The action did not require high levels of joint planning or the investment or re-allocation of substantial resources.	**Workforce and resources** The organisations and individuals involved had limited time available. The limited workforce and insufficient resources meant it was not possible to establish a collaboration at this time.
What was the work?	
Workforce and resources The committee focused on research to identify current policies and practices and to develop model policies. The research was conducted, and it was used to inform the development of model policies to protect children's health and safety.	**Workforce and resources** Because there was little understanding of the nature and extent of the problem, and there had been little history of working together, there was no clear path for action. No further work was carried out.

CASE STUDY 4 Inner West Interagency Partnership and Planning Group

In this example, the conceptual framework has been used to illustrate the ways in which each element contributed to the success of the work of the IWIPPG in developing and implementing the Inner West Child and Family Wellbeing Plan: Doing Better Together.[1]

The COLLABORATION FOR HEALTH FRAMEWORK	INNER WEST INTERAGENCY PARTNERSHIP AND PLANNING GROUP
Why collaborate?	A pre-existing Committee of Senior Executives and Managers of the SLHD and FACS in the inner west of Sydney, had identified shared interests and concerns, with priority being given to child health and wellbeing.
Why now?	A restructure of FACS had resulted in shared administrative boundaries between FACS and the SLHD at the time the IWIPPG was proposed and established. (After several years the administrative boundaries for FACS/DCJ had been changed again and no longer matched those of the SLHD precisely. The IWIPPG was well established by that time.) Pre-existing relationships among NSW Health and FACS professionals were positive. The NSW Department of Premier and Cabinet had expressed the preference to see joined up service delivery. In addition, new funding for 'integrated service provision' was available to the SLHD to facilitate cross-organisational and cross-sectoral collaboration. Together these created a positive authorising policy environment for collaboration – both opportunities and catalysts.

The COLLABORATION FOR HEALTH FRAMEWORK	INNER WEST INTERAGENCY PARTNERSHIP AND PLANNING GROUP
What did the collaboration look like?	The formation of the IWIPPG was authorised by the Senior Executives of the two principal parties as an interagency partnership. An MOU was prepared between the SLHD and FACS. Membership was extended to include representation from the NSW Dept of School Education. Several different organisations from within the health sector were represented. Joint governance was agreed, including joint leadership and facilitation of meetings, regular meetings, formal minutes and regular feedback to senior management in each agency. Working groups were formed to carry out the work. In addition to the formal network of relationships among the people participating in the collaboration, informal networks also developed, enhancing ongoing communication beyond the formal needs of the collaboration.
What capacity did the collaboration need?	The IWIPPG had a workforce that was comprised of Senior Managers from each of the agencies and clinical/technical experts from each of the member agencies. In addition, people with specific expertise were invited to contribute to preparation of the joint plan. Most of the other resources committed were 'in kind', including staff time, people with a wide range of expertise, venues for meeting and administrative support. Funding was available to support the development of the Child Health and Wellbeing Plan and to support the implementation of its recommended actions.

The COLLABORATION FOR HEALTH FRAMEWORK	INNER WEST INTERAGENCY PARTNERSHIP AND PLANNING GROUP
What was the work?	The work included the formation and maintenance of the interagency partnership, communication, building trust and strengthening relationships, managing tensions, and creating a shared understanding of a priority problem and of recommended solutions. The work also included production functions, such as the joint preparation of a plan to improve child health and wellbeing (through improved service provision), to reduce and prevent risks to child health and well-being, and actions to achieve the milestones outlined in the Plan.
What actions were carried out?	The Child Health and Wellbeing Plan was prepared. Four strategic themes were identified: (i) improving system capacity; (ii) health and wellbeing promotion; (iii) early intervention; (iv) place-based approaches. Nine high priority and nine medium priority milestones were identified. Each of the parties to the IWIPPG took responsibility for leading action on some of the milestones. A series of working groups were responsible for taking the actions needed to reach the milestones. An overseeing committee of representatives of each of the parties reviewed progress regularly to ensure that the collaboration continued, to review progress and to problem solve as needed.
Did it work? Monitoring	Monitoring the maintenance of the collaboration: The IWIPPG had been sustained for more than six years (at the time of writing) and has navigated multiple changes, including the restructuring of member agencies, changes (continued over leaf)

The COLLABORATION FOR HEALTH FRAMEWORK	INNER WEST INTERAGENCY PARTNERSHIP AND PLANNING GROUP
Did it work? **Monitoring** (continued)	in boundaries and changed representation at meetings. It has been sustained through shifts in public policy, in available resources, in goals and in the level of senior managerial support from member agencies.
Did it work? **Impact evaluation**	Production outcomes: The implementation of the Plan and its achievements, include: the HHAN Integrated Care Program that demonstrated an approach to system change and improved outcomes at a systemic, professional and client level; multiple actions to improve prevention of and responses to domestic violence; and the development through Health Pathways, of over 100 child related care pathways across agencies and organisations.[96] Five years after the Plan was completed, members of the IWIPPG reported that eight high priority milestones had been reached and actions on five medium priority milestones were on track. Not all parties were engaged consistently in the implementation of all the actions that had been taken to achieve the milestones. Each of the parties to the IWIPPG benefitted from the achievement of at least one (and sometimes more) of the milestones reached.
Are the outcomes sustainable?	Changes in personnel and in the needs and priorities of communities, has resulted in the IWIPPG being reformed under a different structure (Human Service Agencies). However, in 2021 the collaboration has been sustained for eight years. The relationships and the trust built and the experiences of achieving shared goals and positive outcomes proved to be invaluable in responding to the demands on all the organisations, that arose from the COVID-19 pandemic.

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Notes