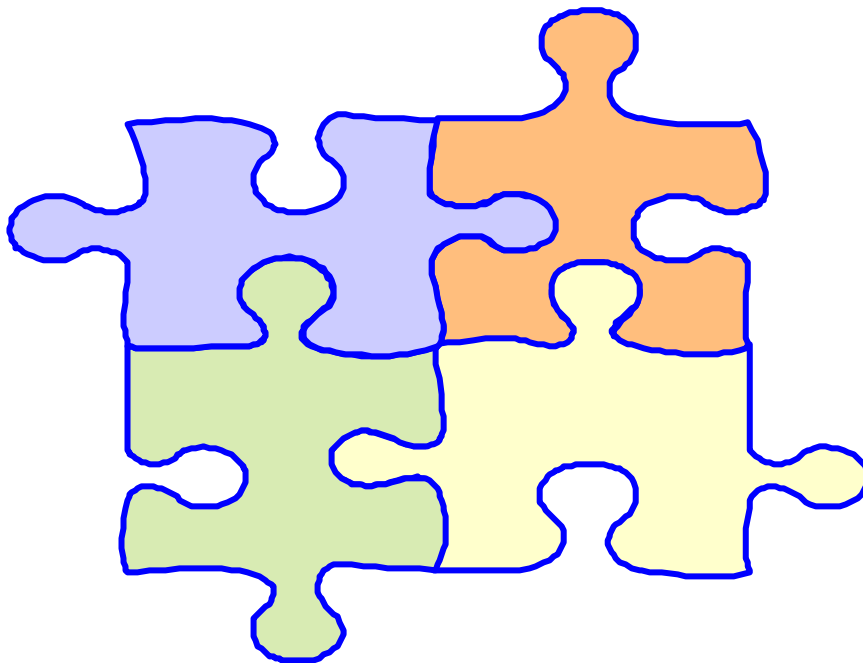


# UPPER HUME PRIMARY CARE PARTNERSHIP

## HEALTH PROMOTION CAPACITY REVIEW



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## INTRODUCTION

The purpose of the Upper Hume Primary Care Partnership (UHPCP) is to define a range of activities that will enhance the integration of the sector, in order to improve the health and well-being outcomes of local communities. The catchment includes the City of Wodonga, Shires of Towong and Indigo.

The UHPCP is responsible for undertaking actions according to outcomes determined by the Department of Human Services. Outcome 3 focuses on Service Development and Planning with a significant health promotion initiative. Specifically, *OUTCOME 3.2 HEALTH PROMOTION STRATEGY*: includes integrated health promotion services and programs that will contribute to the achievement of improved population health outcomes.

The UHPCP called for expressions of interest to undertake this strategy. Upper Hume Community Health, Glenview Community Care, Women's Health Goulburn North East and Upper Murray Health & Community Services agreed to undertake the project as a collaborative venture, each taking a lead responsibility for one stage of the strategy.

The stages and responsible members are as follows:

- 1. To identify the capacity of the UHPCP partners to undertake health promotion** – Upper Murray Health & Community Services.
- 2. To identify and document key service planning processes across the UHPCP and utilise the data to develop a framework to coordinate and evaluate health promotion activities** - Women's Health Goulburn North East.

3. **To implement an integrated health promotion program aimed at addressing a local priority health and wellbeing need** - Upper Hume Community Health Service and Glenview Community Care.

To achieve the outcome of Stage 1 we developed an evaluation strategy utilising an evidence based assessment tool to enable partner members to self assess their health promotion capacity, with support from the project team as required. The self-assessment tool was drawn from the literature on health promotion capacity.

The definition of health promotion capacity that has been used in the development of the tool, and to provide a framework for this review, is 'a system that involves the development of sustainable skills, organisational structures, resources and commitment to health improvement to prolong and multiply health gains many times over' (NSW Health in DHS, 2000).

## **ORGANISATIONAL HEALTH PROMOTION CAPACITY - AN OVERVIEW OF THE LITERATURE**

The first stage of the Project involved a review of the current literature based on organisational capacity to undertake health promotion. The concepts identified in the literature have informed the development of the project framework.

Health promotion has changed significantly from its origins, based on relatively simple models of individual behaviour change to more complex approaches. Health promotion interventions are required to be intersectoral, interagency and multifaceted, with the target group actively participating in the planning, implementation and evaluation of strategies. Health promotion interventions have been conceptualised as a continuum which includes educational and counselling strategies at one end, and policy and legislation change at the other, with organisational and community interventions in between. (Swerissen, 1999).

This project has focused on the later concept of organisational factors and interventions. Swerissen claims a significant body of research on organisational and community factors has emerged. The community factors relate mainly to capacity building, which is emerging as the key determinant of successful organisational and community health promotion strategies. (Hawe, Noort, King & Jordens, 1997 in NSW Health 2000; Crisp, Swerissen, & Duckett cited in Swerissen, 1999).

Bensberg has also stressed the importance of capacity building for health promotion. She has described the need for effective and sustainable health promotion that goes beyond designated staff and adequate resources, to include intersectoral coordination and organisational development, capable of enhancing the community's

health (Bensberg, 2000 & Duckett cited in Bensberg, 2000). Bensberg's reasoning is that specific interventions aimed at target populations need to be balanced with broader efforts to build the capacity of organisations and communities to promote good health.

As stated in the introduction, capacity building has been summarised as a system that involves the development of sustainable skills, organisational structures, resources, and commitment to health improvement in the health and other sectors, to prolong and multiply health gains many times over (NSW Health in DHS, 2000).

Three main aspects of capacity building have been identified. These include:

- 1. Agency And System Infrastructure:** The capacity to deliver particular program responses to particular health problems, including the establishment of minimum requirements in structure and skills.
- 2. Program Maintenance And Sustainability:** The capacity to continue to deliver, transfer and/or adapt a particular program through a network of members, or to sustain the benefits achieved.
- 3. Problem Solving Capability Of Organisations And Communities:** The capacity of a more generic kind. To develop innovative solutions, learning through experience and applying these lessons.

(Adapted from Hawe, King, Noort, Jordens & Lloyd in DHS, 2000).

Bensberg's model of Infrastructure for Improving Health Promotion in Table 1, describes a set of domains identifiable by settings, stakeholders and mechanisms, elements, and activities within these domains (Bensberg, 2000). The elements

highlight options to be addressed to improve local health promotion systems. Bensberg adds that while all of the elements are important to support health promotion practice, not all of them will be relevant to individual members. The point she is making is that the change that can occur as a result of working with any one element or simultaneous strategies can create a synergy that will produce results that are durable and sustainable.

**Table 1. Adapted from Regional Infrastructure for Improving Health Promotion (RIHP) Bensberg, 1998 in Bensberg 2000, p 69.**

<b>DOMAIN</b>	<b>ELEMENTS</b>
<b>1. Health Promotion Knowledge</b>	Best Practice/Evidence Professional associations Research Workforce training & education
<b>2. DHS/Regional &amp; Head Office</b>	Management and staff skills Policy, Planning processes & data availability Financing arrangements & resources
<b>3. Alliances</b>	Between agency relationships Shared planning, resources, information, knowledge & skills.
<b>4. Providers - Management</b>	Management skills Agency mission or mandate & culture Quality assurance processes, policy Planning processes & data availability.
<b>5. Providers - Practitioners</b>	Staff skills, training, professional principles Internal health promotion committee Resources
<b>6. Community</b>	Mechanisms for community participation
<b>7. Communication</b>	Newsletters, forums, conferences, alliance meetings and journals.

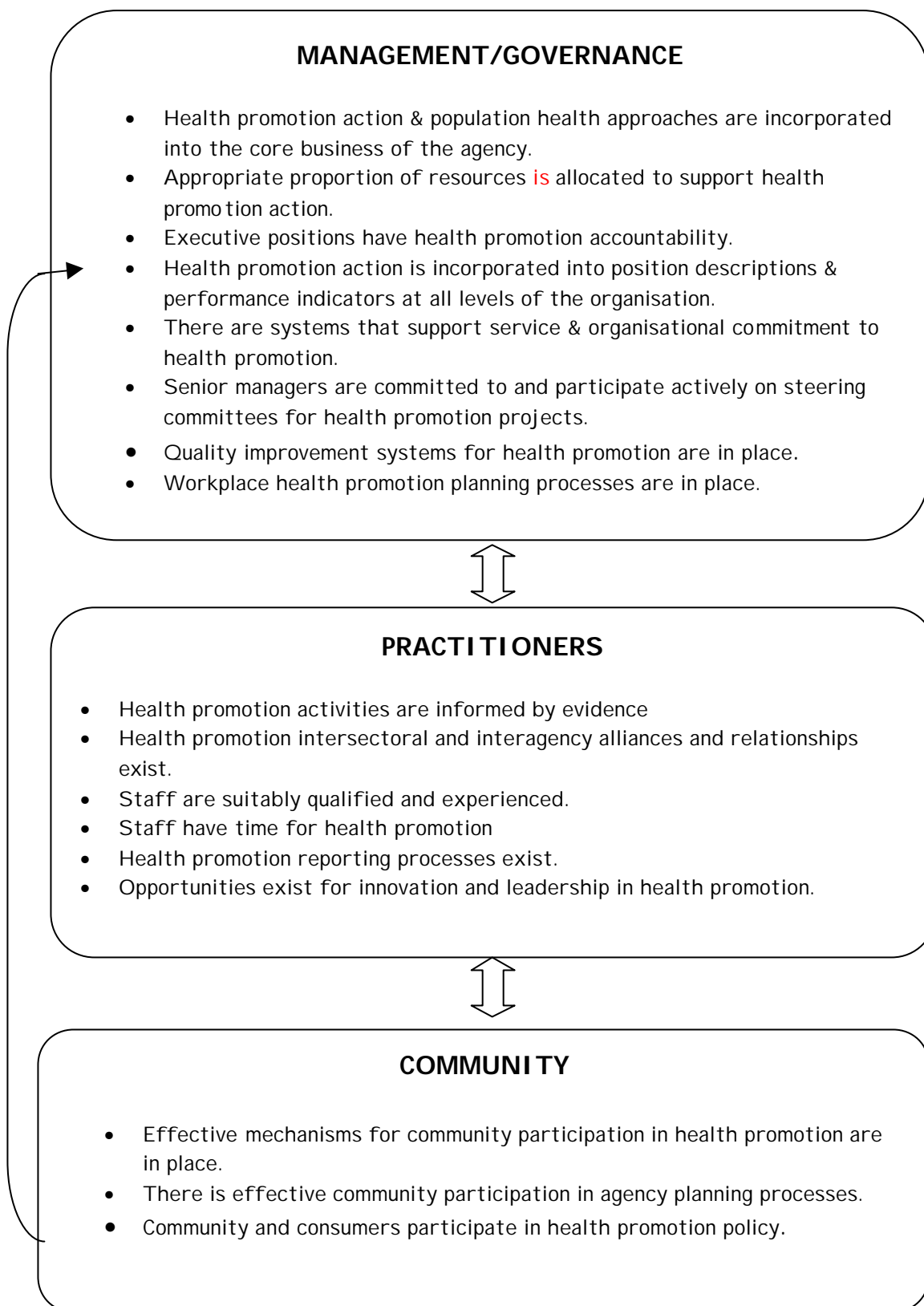
Bensberg's model was proposed as part of the Regional Infrastructure for Improving Health Promotion Program funded by the Victorian State Government in 1998. It drew upon organisational change theory and capacity building methods in consultation with practitioners, academics and policy makers. Howe et al's (2000) three main aspects of capacity building essentially could be identified as a broad summary of Bensberg's elements of health promotion infrastructure.

## **PROJECT MODEL**

This project has linked the theories around health promotion capacity with the outcomes for the Upper Hume PCP Health Promotion Project. This has enabled us to develop an evaluation strategy capable of identifying the capacity of the Upper Hume PCP to undertake health promotion.

A set of health promotion domains, identifiable by settings, stakeholders and mechanisms, have been developed through the process described above. In this model, elements within each domain that highlight health promotion infrastructure, are examined to quantify health promotion capacity. Table 2 outlines the model utilised by the review.

**Table 2. Model for Determining Health Promotion Capacity of the UHPCP**



## DESIGN & METHODS

A self-assessment tool was developed that linked the theories around health promotion capacity with the outcomes for the Upper Hume PCP Health Promotion Project. Elements within each domain, which highlight health promotion infrastructure, were evaluated using a rating to quantify health promotion capacity.

The three domains that formed the broad structure of the assessment included: management & governance, practitioners, and the community. The domains were identifiable by settings and stakeholders. The elements within each of these domains were evaluated with a rating.

As described above, the tool, (see Appendix A), was drawn from the best practice literature. It was developed with the assistance of a number of members through participation in a workshop in April 2001. The tool was developed in a familiar format consistent with health service accreditation self-assessment tools. However, it was understood that processes such as these could be onerous, particularly when it relates to a new area of evaluation. Subsequently, we were keen for the process to be simplified as much as possible and to add value to operations, rather than represent an additional burden. Site visits to assist with the process were offered and undertaken in June 2001. The members visited are listed in Table 3, with each visit ranging from 0.5 to 2.5 hours and comprising of a meeting with key executive staff and staff coordinating or involved in health promotion activities. Their participation was important to clarify and consolidate the information obtained through the self-assessment

**Table 3: List of Participating Members**

<b>PARTICIPATING MEMBERS</b>
<ul style="list-style-type: none"><li>• 3 Local Government Services</li><li>• 2 Family and Children's Services</li><li>• 1 Regional Health Service</li><li>• 1 Mental Health Service</li><li>• 2 Community Health Services</li><li>• 1 Multi Purpose Service</li><li>• 1 Healthstreams Service</li><li>• 1 District Hospital</li><li>• 1 Aboriginal Corporation</li><li>• 3 Regional Primary Health Service Providers</li><li>• 2 Divisions of General Practitioners</li></ul>

How members used the tool depended on how health promotion was structured within the agency and the resources available to undertake activities such as this one. Members used a variety of staff, including health promotion staff or community services team leaders, to coordinate the completion of the tool. Most members elected to complete the tool in consultation with the site visit consultant.

Each of the elements/indicators had a rating based on the EQulP format. Members were asked to nominate their achievement from the following levels:

**Outstanding Achievement (OA)** – where an agency has demonstrated that it has achieved all the requirements of the elements/indicators, and that it has done additional work to expand the implementation of the elements/indicators.

**Extensive Achievement (EA)** – where an agency has demonstrated that it has achieved most of the requirements of the indicators/elements.

**Some Achievement (SA)** – where an agency can demonstrate that it is attempting to achieve the requirements of the elements/indicators.

**Little Achievement (LA)** – where an agency has not attempted to achieve the elements/indicators.

**Not Applicable (NA)** – where the service can demonstrate that it cannot attain the level required due to it being prohibited by legislation or by funding, policy or guidelines.

Whilst the self-assessment achievement rating was essentially a quantitative measure, the site visits in many cases provided the opportunity for in-depth discussions around health promotion capacity, and added a rich qualitative dimension to the review.

Validity has been enhanced by the involvement of members in the evaluation process and the presentation of the draft findings to all interested members at a workshop in August 2001.

Data analysis has focused on health promotion strengths and best practice within the UHPCP, in addition to identifying the gaps in structures, knowledge or skills. The reason for this is that rather than simply provide the UHPCP with a gap analysis, the evaluation will enable the Partnership to access and benefit from the significant capacity that already exists within its membership. The UHPCP can also provide support to organisations with less resources or those less highly developed in terms of health promotion capacity.

## **FINDINGS AND GENERAL ANALYSIS**

The purpose of this report is to inform the UHPCP of the health promotion capacity of the Partnership. The information is required by the UHPCP at a number of levels. Firstly, the report is designed to provide information about the ability of the UHPCP, as a partnership, to undertake health promotion activities and support health promotion within its geographic catchment. Secondly, information consolidated from individual member reviews will enable the UHPCP to support organisational development activities in health promotion capacity building. Thirdly, the UHPCP will benefit from the ability to access support for training & development and other capacity building activities from its partner members, through the identification of best or exemplary practice within the UHPCP.

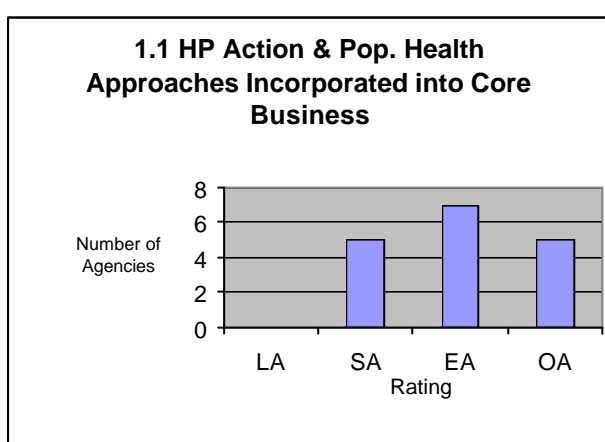
The following analysis describes the overall performance of the UHPCP with regard to the individual health promotion indicators for the three domains: management & governance, practitioners, and the community. The elements within each of these domains, shown in Table 2, are evaluated with a rating and presented as the number of services falling into each rating level (presented graphically). The discussion around each indicator will provide an overall rating for the UHPCP and identify examples of exemplary structures, practices, knowledge and skills, as well as areas of low performance or opportunities for improvement. Individual members are not identified.

## KEY AREA 1. MANAGEMENT AND GOVERNANCE

### Indicator 1.1: Health Promotion Action And Population Health Approaches Are Incorporated Into The Core Business Of The Agency.

#### FINDINGS/DISCUSSION:

The overall performance of the UHPCP regarding health promotion action and



population health approaches was assessed as strong. A population health approach is a method that explicitly links interventions to health status. A systematic and collaborative assessment of population needs, designed to identify priority health issues, is undertaken. Determinants and associated risk factors are identified

together with information and evidence of methods that strategically act upon health issues.

The majority of members performed in an achievement range from extensive to outstanding. A number of members were exemplars of best practice and the UHPCP has a significant capacity to provide guidance to organisations wishing to incorporate this approach. Indications of outstanding performance were evident where mission and vision statements reflected primary health care principles and the social model of health. Vision statements such as 'working for a healthy community' and 'enhancing the health and wellbeing of the community' support the notion of health promoting members.

Likewise, mission statements that included statements such as 'services that strengthen individuals and families' and 'promoting wellbeing and independent living' reflected a commitment to population health. Several members have service and corporate planning processes that respond to identified community needs. Health promotion strategies, in these organisations, reflect evidence of this need and staff have been provided with the skills and resources based on this evidence.

Where there was less achievement members were often limited by reporting requirements and program funding restraints, where funds need to be acquitted against client contacts or other output measures. Other gaps identified were the absence of a link between community need and service, and corporate planning processes.

#### **RECOMMENDATIONS:**

That the UHPCP support members:

- to link assessed health needs to service & corporate planning processes; and
- to understand the links between the organisational development and community development, with regard to building the capacity of organisations to develop a population health perspective, and to undertake effective health promoting activities.

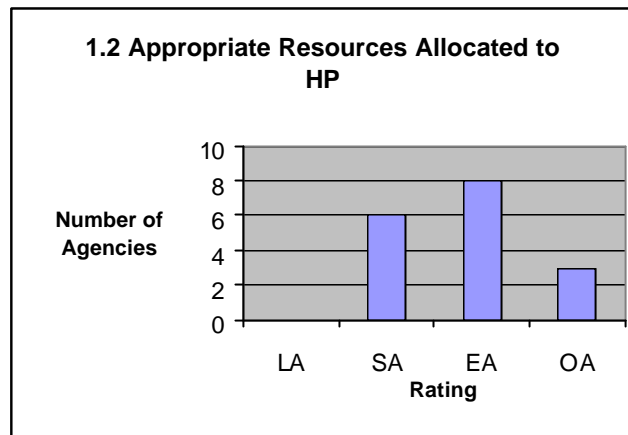
That the UHPCP

- through Working Group 3 showcase members achievements with regard to health promotion action and population health approaches.

## Indicator 1.2: Appropriate Proportion Of Resources Are Allocated To Health Promotion.

### FINDINGS/DISCUSSION:

Whilst the majority of organisations allocated significant resources to health promoting activities, in approximately 35% of cases the level of resource allocation was self-assessed as inadequate. Some opportunities exist for the



organisations with outstanding achievement in this area, to inform members of the costs and benefits associated with this level of resourcing for health promoting activities. Where members self-assessed lower levels of achievements it was a lack of specifically allocated resources that was most commonly reported. Participants also noted that program funding and reporting requirements often failed to acknowledge both the effectiveness and cost effectiveness of health promoting activities, with funds needing to be acquitted against client contacts at the treatment or secondary prevention end of the service continuum.

On the other hand, some members had been resourceful in this area and added health promotion to the role of many existing programs while others had pooled resources and established dedicated positions. It was evident that many practitioners seemed to be unaware of how resources are allocated and how decisions relating to resource allocations are made within their organisations.

The findings indicate that further work is required to convince major funding bodies, such as the Department of Human Services, to acknowledge health promotion as an

essential component of all primary health and community support services, and to reflect this understanding in their funding guidelines. In addition to this, members will benefit from applying community development principles to their organisational development activities, in particular processes relating to decision-making and resource allocation.

#### **RECOMMENDATIONS:**

That the UHPCP:

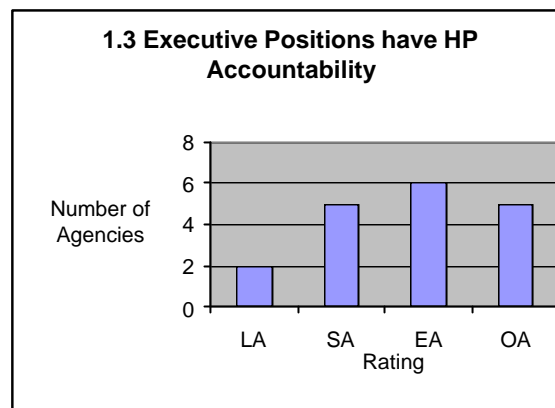
- lobby the Department of Human Services to acknowledge the importance of health promoting activities at all levels of service provision and to reflect this understanding in their funding guidelines; and
- support agency boards and management to gain an understanding of the relevance of community development principles to organisational development, in order to build the capacity of their organisations to undertake effective health promoting and community development activities.

#### **Indicator 1.3 & 1.4: Executive Positions Have Health Promotion Accountability & Positions At All Levels Have Responsibility For Health Promoting Actions.**

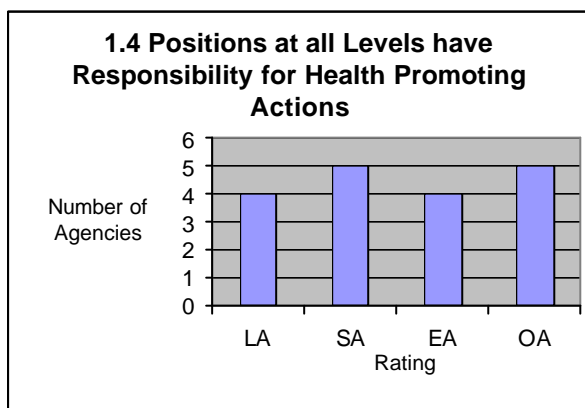
#### **FINDINGS/DISCUSSION :**

The UHPCP has displayed some capacity, not only in terms of senior positions having health promotion accountability, but also regarding positions at all levels having responsibility for health promoting actions. Unfortunately nearly 50% of members displayed little capacity in these areas, though the majority of participants expressed a desire to develop their executive performance indicators and position descriptions to reflect the importance of these responsibilities within their service.

Members with outstanding achievement utilised appropriate performance indicators for executive staff relating to health promotion and community development, and included health promoting actions or responsibilities in most position descriptions. In addition to this some



members linked satisfactory senior management performance to the achievement of specific health promotion and community development activities described in



corporate and business plans, as well as framing position descriptions and programs within a social model of health and/or community development principles.

Other exemplars of outstanding performance included the allocation of responsibility to specific staff for the coordination of staff health promotion programs, in addition to traditional occupational health & safety activities.

**RECOMMENDATIONS:**

That the UHPCP:

- support members to develop appropriate health promotion performance indicators at an organisational and senior management level.

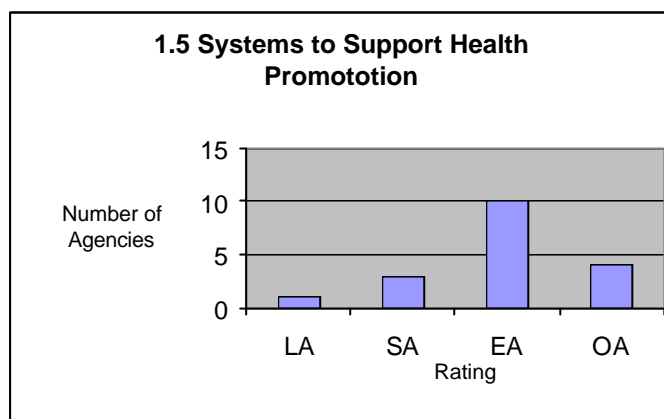
That the UHPCP members:

- include staff health promotion as a training and development priority.

## Indicator 1.5: There Are Systems To Support Service And Organisational Commitment To Health Promotion.

### FINDINGS/DISCUSSION :

Systems to support health promotion include structures such as inter and intra



agency networks, health promotion committees, corporate and service plans, policies, procedures, positions dedicated to health promotion coordination, consumer advocacy, and community participation strategies. As depicted in the graph the capacity

of the UHPCP is significant in this regard, with the majority of members showing extensive or outstanding achievement. The challenge for UHPCP members is to utilise health promotion support systems to achieve more in areas that are less well developed. Achievement in this area was obviously enhanced through membership of the UHPCP, which was seen as a significant support system in itself by the majority of partner members.

### RECOMMENDATIONS:

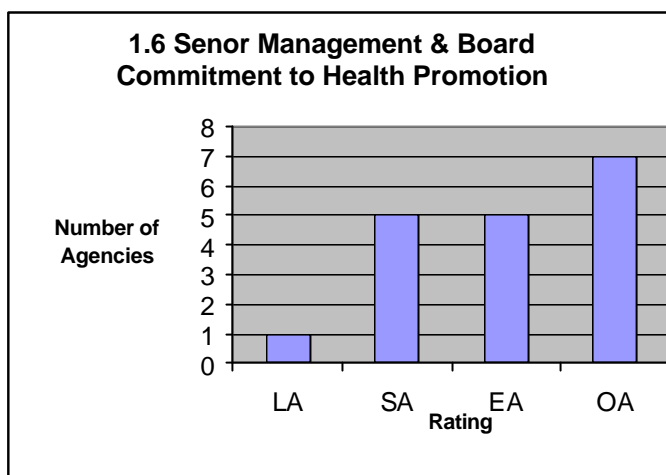
That UHPCP members:

- build on the support systems they have in place to develop areas of less achievement; and
- develop a formal support structure, accessible by all staff, with similar objectives to the former North East Victorian Centre for Health Promotion.

## Indicator 1.6: Senior Management & Board Members Commitment To Health Promotion Exists.

### FINDINGS/DISCUSSION :

The significance of this indicator is the link that has emerged with the other indicators, regarding outstanding or low achievement. Where members have self-assessed as outstanding achievement, regarding management and board commitment, they have generally had extensive or outstanding



levels of achievement in most other areas of the review. Unfortunately the reverse was also true, where members fared less well regarding management and board support they generally fared less well in other areas of the review.

Exemplars of outstanding achievement included senior managers and board members participating on health promotion committees and projects, senior managers providing leadership with regard to community development and consumer participation strategies, board business papers and agenda's including health promotion and community development issues, and board and management support to allocate resources to health promoting activities.

**RECOMMENDATIONS:**

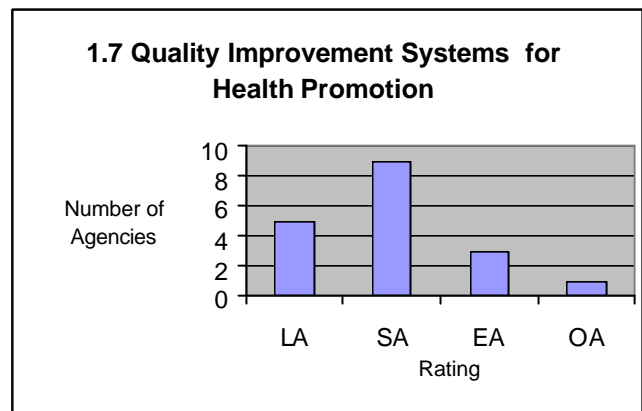
That the UHPCP:

- take a lead role with regard to developing strategies to demonstrate the value of health promoting activities to senior management and boards.

**Indicator 1.7: Quality Improvement Systems For Health Promotion Are In Place.**

**FINDINGS/DISCUSSION :**

The majority of members self-assessed their performance regarding quality improvement systems for health promotion in the lower achievement levels. Some Achievement (SA) generally reflected membership in the QICSA program, which has a strong health



promotion and community development focus. Members that self-assessed as having extensive or outstanding achievement had generally developed specific objectives, indicators and strategies relating to health promotion, community development and consumer participation. Other exemplary or outstanding performance included the use of self- assessment tools such as the National Resource Centre for Consumer Participation in Health Self-Assessment Tool for Consumer Participation, to identify quality improvement priorities and best practice strategies for improvement.

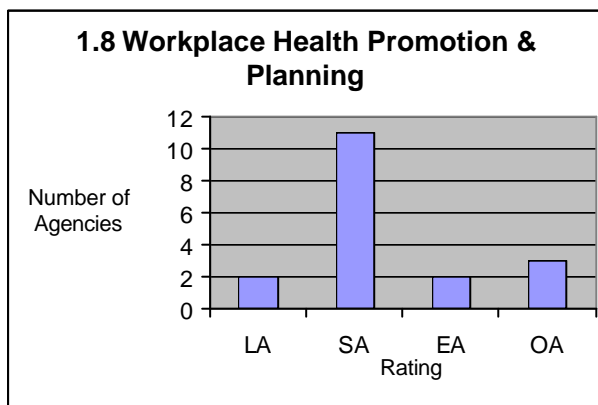
**RECOMMENDATIONS:**

That the UHPCP:

- Health Promotion Capacity Self-Assessment Tool be provided to all partner members to inform their health promotion quality improvement processes; and
- develop a training and development plan which includes education and training relating to quality improvement for health promotion.

**Indicator 1.8: Workplace Health Promotion Planning & Processes Are In Place.**

**FINDINGS/DISCUSSION :**



The area of workplace health promotion planning, like quality improvement for health promotion is an area of poor performance for the UHPCP overall. Few members have self-assessed their performance above the level of some achievement (SA). Unfortunately this indicator was complicated by the

combination of planning and workplace health promotion activities in the one indicator. Fortunately, the examples offered by members has enabled a reasonable evaluation. Surprisingly, health promotion planning activities were identified as an area of overall weakness. Exemplary practice saw health promotion processes such as committees and plans linked strongly to rigorous needs assessment and evidence based interventions and strategies. With regard to workplace health promotion programs, many examples of exemplary practice were identified. Outstanding achievement reflected a whole of organisation approach, where the overall culture of

the organisation was highly supportive, with organisational development reflecting community development principles regarding building the capacity of individuals, teams, and the overall organisation.

The organisations with this type of culture, as identified in the review, had flat management structures, useful financial and management delegations, flexible work practices, staff health programs and family-friendly environments. Exemplars of flexible work practices included, flexible working hours, the ability to work from home, flexible use of leave, and flexible policies relating to family and children at work.

Examples of workplace health programs included access to: walking groups, Yoga and Thai Chi classes, relaxation programs, massage, aerobics, a workplace gymnasium and fitness programs, social clubs, quit smoking and healthy lifestyle programs, in addition to traditional occupational health and safety programs.

#### **RECOMMENDATIONS:**

That the UHPCP

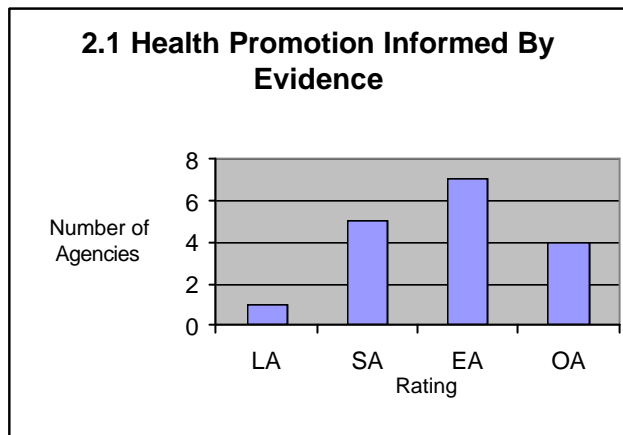
- members be supported, through links to the Community Health Plan, to include health promotion planning in their service and business planning processes;
- support organisational development as a key learning area for board members and senior staff;
- develop a training module for organisational development that links organisational development to community development and primary health care principles; and
- through Working Group 3 showcase members achievements with regard to staff health promotion programs.

## KEY AREA 2. PRACTITIONERS

### Indicator 2.1: Health Promotion Activities Are Informed By Evidence.

#### FINDINGS/DISCUSSION :

Overall, the UHPCP has considerable capacity with regard to evidence-based approaches to service development and interventions. The majority of members self-assessed their achievement as extensive or better, with regard to health promotion activities being informed by evidence. Analysis of individual members responses has identified a significant difference between members, in terms of what constitutes evidence. Despite this, the majority of members have made considerable effort to link locally identified needs and priorities to service interventions and health promoting activities.



Exemplars of an evidence-based approach involved fairly rigorous processes, linking local socio-demographic and health profiles with community priorities, and the evidence of effective and cost effective services and interventions.

**RECOMMENDATIONS:**

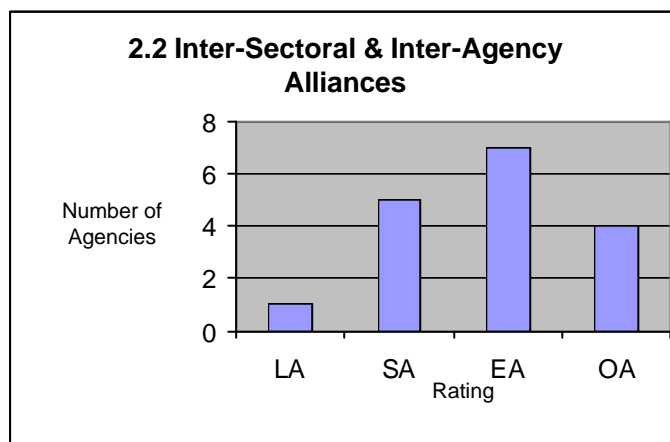
That the UHPCP:

- prioritise population health approach needs assessment and the use of evidence in service planning as a training & development priority; and
- utilise the capacity that exists within the UHPCP to deliver this training.

**Indicator 2.2: Health Promotion Intersectoral And Interagency Alliances And Relationships Exist.**

**FINDINGS/DISCUSSION:**

The UHPCP has shown significant capacity in the area of alliances, relationships and networks. Many members have effective partnerships with local and regional organisations to address health problems. This is most evident at program level,



where members acknowledge the need to work with other organisations to ensure programs utilise pooled resources and are appropriate to the target group.

The smaller members provide exemplars in this area. These

members highly value the need to work with local and regional providers for purposes of planning, service coordination, case management and care coordination. However, a number of members identified the significant cost of resourcing these networks and the inability to backfill staff adding increased work-loads for individuals concerned.

Where members self-identified low achievement, they cited a lack of support and resources to support alliances and networking.

Intersectoral alliances were generally assessed as an area of under achievement. Intersectoral alliances may be described as direct relationships with other sectors, which involve joint planning or action on a health related issue, with the explicit aim of improving individual and community health.

#### **RECOMMENDATIONS:**

That the UHPCP:

- supports the need to resource members for participation in the UHPCP and other DHS initiatives that require considerable commitment from members.

That the Women's Health Goulburn North East Project for health promotion planning and coordination identifies:

- what alliances exist in communities of interest to ensure all members are provided with the opportunity to participate; and
- intersectoral alliances across the UHPCP for health promotion purposes, identifying how better to progress cross sector health promotion initiatives.

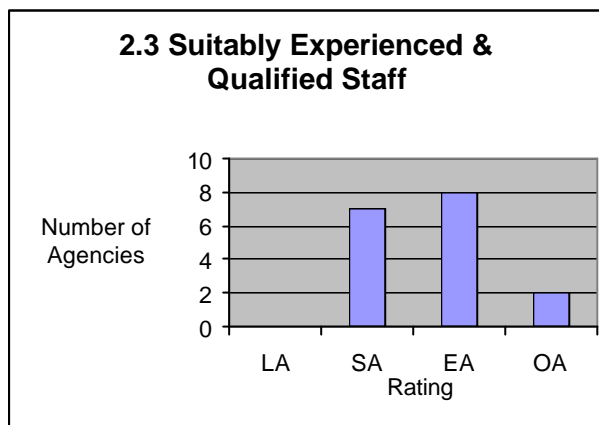
### **Indicator 2.3: Staff Are Suitably Experienced And Qualified.**

#### **FINDINGS/DISCUSSION :**

The findings for this indicator varied considerably, with most members self-reporting some or extensive achievement. The indicator was extensively achieved where staff were suitably experienced and qualified to provide and support health promotion initiatives. Members with extensive or outstanding performance valued staff with qualifications and/or expertise in public health, primary health care,

health promotion or community health, for their broad organisational contribution at both informal and formal levels.

Exemplars of staff support were evident when staff had access to current evidence through information on relevant courses and conferences, and access to the internet



and libraries and/or subscriptions to primary health care and health promotion journals.

Where this indicator was underachieved, members reported a lack of support for staff development and training in health promotion. In addition staff did not have easy access to the internet or a library as a means to gathering evidence and information needed for current practice.

#### **RECOMMENDATIONS:**

That the UHPCP:

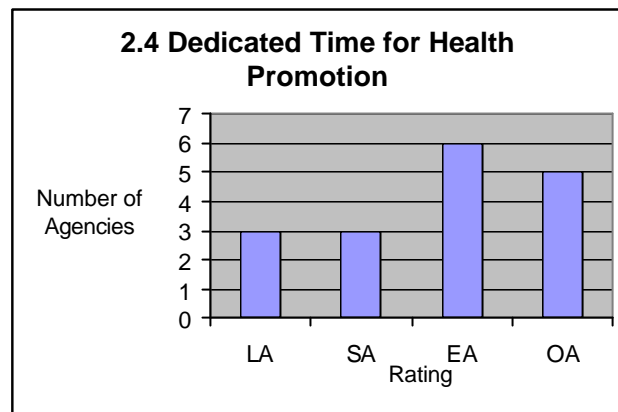
- facilitates and supports local skills-based health promotion courses that are affordable, accessible and relevant to rural practitioners;
- acknowledges the need for all health workers to add value to their practice by understanding and applying the principles of primary health care;
- supports the establishment of health promotion networks for providers to share knowledge and skills and peer support systems;
- uses the IT strategy to enable all health workers to have easy access to the internet for information purposes; and
- seeks application for all health workers to have access to the La Trobe University Albury-Wodonga library.

## Indicator 2.4: Staff Have Dedicated Time For Health Promotion.

### FINDINGS/DISCUSSION :

Most members self-reported dedicated time for health promotion. However, staff reported that achieving a balance with competing priorities was difficult as many had other roles and functions.

Again, members reported being restricted by funding and reporting guidelines, which often do not allow for health promotion activities.



Exemplars in this area were evident where there was dedicated staff for health promotion and community development. These workers coordinated health promotion initiatives. Other exemplars saw health promotion committees and plans linked strongly to rigorous needs assessment and evidence based interventions and strategies.

### RECOMMENDATIONS:

That the UHPCP:

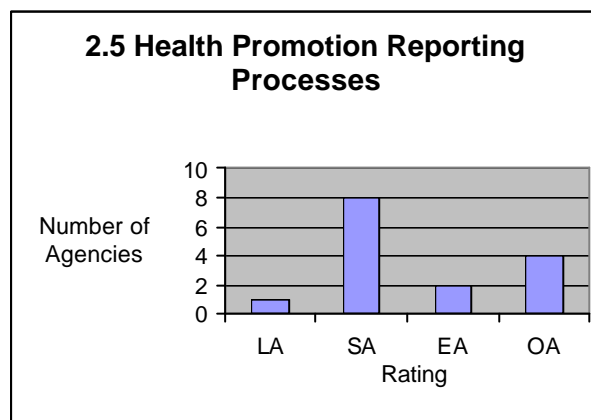
- lobby the Department of Human Services to acknowledge the importance of health promoting activities at all levels of service provision, and to reflect this understanding in their funding guidelines; and
- support members to utilise funding flexibly to pool health promotion resources for the purposes of establishing dedicated health promotion & community

development positions and allocate time and resources for all staff to participate in health promoting activities.

## Indicator 2.5: Health Promotion Reporting Processes Are In Place.

### FINDINGS/DISCUSSION :

Intra agency health promotion reporting is difficult to assess, with members developing various tools to support their action. However, consistent use of best



practice tools for health promotion reporting was self-assessed as mostly underachieved across the UHPCP.

Exemplary members had policies and procedures that enabled consistent reporting. The reports scoped planning,

intervention and evaluation processes. In many cases members only reported health promotion activity through an agency newsletter or as highlighted in annual reports.

### RECOMMENDATIONS:

That the UHPCP:

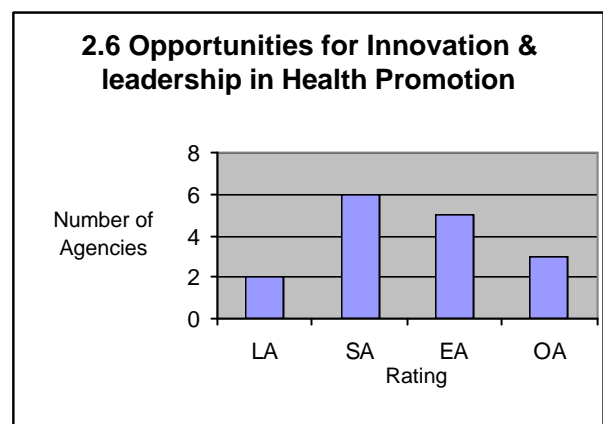
- identify best practice tools for health promotion activity reporting; and
- support, through education and training, and consultation with practitioners, the development of minimum standards in health promotion reporting.

## Indicator 2.6: Opportunities Exist For Innovation And Leadership In Health Promotion.

### FINDINGS/DISCUSSION :

Organisations with strong capacity for health promotion reported high levels of staff satisfaction, where staff felt they were acknowledged for their leadership and innovation. This included feedback at meetings, staff and management support, recognition of staff training and development needs, and the availability of mentoring and supervision.

Devolved and shared decision making around resource allocation also enabled leadership and innovation in health promotion.



Staff satisfaction and motivation were linked to agency support for health promotion at all levels. Where members supported and acknowledged health promotion as a priority, innovation and leadership were evident.

Where members self-assessed as having some achievement in this area, they cited restrictions in reporting and funding guidelines that stifled innovation and leadership in health promotion.

## **RECOMMENDATIONS:**

That the UHPCP:

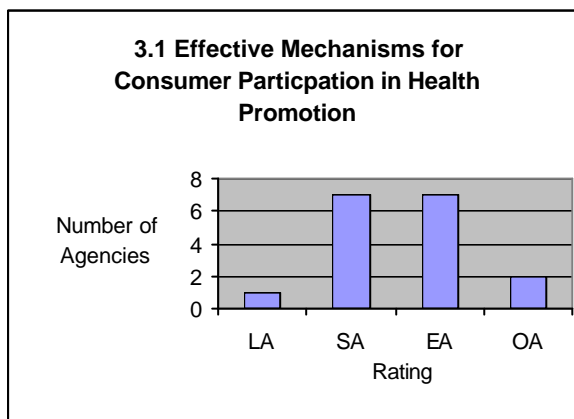
- members be supported, through links to the Community Health Plan, to include health promotion planning in their service and business planning processes.
- lobby the Department of Human Services to acknowledge the importance of health promoting activities at all levels of service provision and to reflect this understanding in their funding and reporting guidelines;

## KEY AREA 3. COMMUNITY PARTICIPATION

### Indicator 3.1: Effective Mechanisms Exist For Community Participation In Health Promotion.

#### FINDINGS/DISCUSSION :

Once again, despite approximately 50% of UHPCP members reporting little or some



achievement, considerable capacity exists within the UHPCP for community and consumer participation. Where members report extensive or outstanding achievement they generally engage consumers in health promotion planning processes. In addition, these members had

the flexibility to respond to individuals and groups, as well as demonstrating that they understand their community of interest.

Most members reported the ability to respond to community groups with information and education as required, and identified at least some capacity to engage consumers in health promotion planning processes.

The recommendations for community participation have been summarised in 3.3.

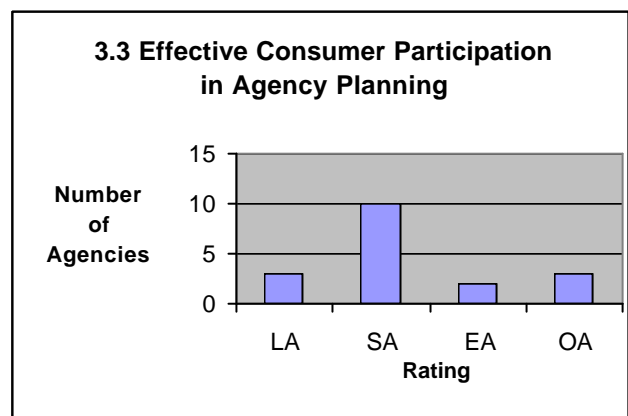
## Indicator 3.2: There Is Proven Effective Community Participation In Agency Planning Processes.

### FINDINGS/DISCUSSION :

Consumer participation strategies, regarding agency planning activities, varied across the UHPCP, with most reporting some achievement in this area. Exemplars of effective consumer participation were evident where members had supported and trained representative groups to participate in all levels of agency planning, including corporate, service, and program planning. Other exemplar strategies included having consumers on quality management teams and nominated consumer advocates. One agency reported winning two Commonwealth Department of Health & Aged Care, Consumer Participation and Collaboration Grants to document their achievements in consumer participation in planning, resources allocation and quality improvement.

Members often referred to governance input as the main strategy for consumer consultation. While this is important, it is

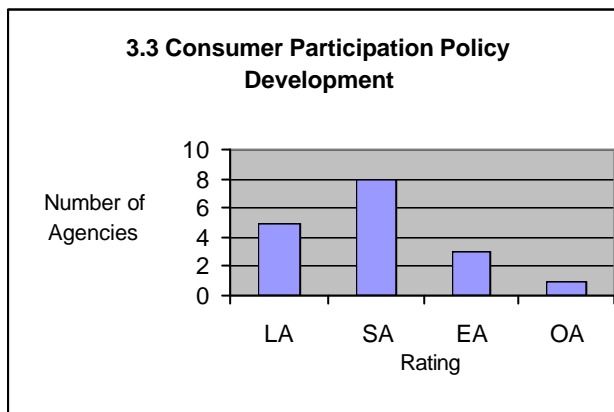
generally understood that while governance members represent some sectors of the community, they are selected for their governance skills and not on the basis of their representativeness of their community.



### Indicator 3.3: Community/Consumers Participate In Health Promotion Policy Development.

#### FINDINGS/DISCUSSION :

Similar to the other community and consumer participation indicators, members



mostly reported underachievement in this area. Where members did not have effective mechanisms for consumer participation, they had little ability for consumers to influence agency policies.

Exemplars of this indicator included the development of community advisory or liaison groups and/or community advocate roles that had input into policy development and approval.

#### RECOMMENDATIONS:

That the UHPCP:

- support the development of effective consumer participation strategies in health promotion through the Community Health Plan.
- utilise the capacity that exists within the UHPCP to support members to implement effective community and consumer participation strategies.

## SUMMARY OF FINDINGS

The review has clearly shown that a significant capacity exists within the UHPCP to undertake health promoting activities, provide training and development in the priority areas identified below, and to support capacity building activities of members. In all areas of the review at least one, and generally two to three members, have reported and demonstrated outstanding achievement. These members have not been identified as the intention was to review the capacity of the PCP as a whole.

The Department of Human Services (DHS) Primary Care Partnerships – Draft Health Promotion Guidelines, identifies five key action areas for building capacity to promote health. These are Organisational Development, Resource Allocation, Workforce Development, Leadership and Partnerships. The recommendations have been placed within the key action areas for purposes of consistency with the DHS guidelines.

### **Organisational Development Recommendations:**

That the UHPCP:

- support members to link assessed health needs to service & corporate planning processes;
- support organisations to develop a population health perspective and undertake effective health promoting activities;
- support members to develop appropriate performance indicators at an organisational and senior management level;
- enable the UHPCP Health Promotion Capacity Self-Assessment Tool to be provided to all partner members to inform their health promotion quality improvement processes;

- through Working Group 3 showcase members achievements with regard to health promotion action and population health approaches; and
- support the development of effective consumer participation strategies in health promotion through the Community Health Plan.

That UHPCP members:

- build on the support systems they have in place to develop areas of less achievement; and
- be supported, through links to the Community Health Plan, to include health promotion planning in their service and business planning processes.

## **Workforce Development Recommendations**

That the UHPCP:

- supports organisational development for health promotion to be prioritised as a priority learning area for board members and senior staff;
- develop a training module for organisational development that links organisational development to community development and primary health care principles, in order to build the capacity of their organisations to undertake effective health promoting and community development activities;
- support member's boards and management to gain an understanding of the relevance of community development principles to organisational development;
- prioritise needs assessment processes and the use of evidence in service planning as a training & development priority, and utilise the capacity that exists within the UHPCP to deliver this training;
- include processes for training and development relating to quality improvement for health promotion;

- facilitate local skills-based health promotion courses that are affordable, accessible and relevant to rural practitioners;
- uses the IT strategy to enable all health workers to have easy access to the internet for information purposes;
- seeks application for all health workers to have access to La Trobe University Albury-Wodonga library;
- identify best practice tools for health promotion activity reporting; and
- support, through education and training, and consultation with practitioners, the development of minimum standards in health promotion reporting.

That UHPCP members:

- acknowledge the need for all health workers to add value to their practice by understanding and applying the principles of primary health care;
- include staff health promotion as a training and development priority.

## **Resource Allocation**

That the UHPCP:

- supports members to utilise funding flexibly to pool health promotion resources for the purposes of establishing dedicated health promotion & community development positions and to allocate time and resources for all staff to participate in health promoting activities;
- supports the need to resource members for participation in the UHPCP and other DHS initiatives that require considerable commitment from members;
- lobby the Department of Human Services to acknowledge the importance of health promoting activities at all levels of service provision and to reflect this understanding in their funding guidelines.

## **Partnerships**

That the UHPCP:

- develop a formal support structure accessible by all staff in members, with similar objectives to the former North East Victorian Centre for Health Promotion.
- identify what alliances exist for health promotion in communities of interest to ensure all potential stakeholders are provided with the opportunity to participate; and
- identify intersectoral alliances across the UHPCP for health promotion purposes identifying how better to progress cross-sector health promotion initiatives.

## **Leadership**

That the UHPCP:

- identify the ability to showcase member's achievements regarding staff health promotion programs.
- support the establishment of health promotion networks for providers to share knowledge and skills and peer support systems;
- take a lead role with regard to developing strategies to demonstrate the value of health promoting activities to senior management and boards;
- utilise the capacity that exists within the UHPCP to support members to implement effective community and consumer participation strategies.

## CONCLUSION

The purpose of the Health Promotion Capacity Review was to identify the capacity of Upper Hume Primary Care Partnership (UHPCP) to undertake health promotion and identify priorities for staff and board training and development. However, the development of an appropriate review strategy clearly identified the importance of the review taking a much broader perspective to include the identification of organisational development priorities for the UHPCP.

The project team developed an evaluation strategy drawn from the best practice literature and based on a self-assessment tool. This has enabled partner members to evaluate and report their own health promotion capacity, with support from the project team as required.

The project team has made every effort to undertake this review in a way that is consistent with the current climate of the UHPCP. The UHPCP has consistently supported the development of partners by supporting members to build their capacity by undertaking projects or programs on behalf of the partnership, rather than utilising external expertise.

Subsequently this review has been equally concerned with identifying the existing capacity of the UHPCP to support the development of members, as it has been in identifying organisational gaps or deficiencies and training and development priorities.

## REFERENCES

Adapted from Hawe, P., King, L., Noort, M., Jordens, C. and Lloyd, B. (2000). Indicators to Help with Capacity Building in Health Promotion, NSW Health, Sydney in Primary Care Partnerships Draft Health Promotion Guidelines. Department of Human Services, Melbourne

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# **APPENDIX A**

## **Health Promotion Capacity**

### **Self Assessment Tool**

**UPPER HUME PRIMARY CARE PARTNERSHIP –**

**WORKING GROUP 3**

**HEALTH PROMOTION PROJECT**

**Health Promotion Capacity Self Assessment Tool**

**CONTACT PERSONS:** Frank Evans Ph 0260763202 [Frank.Evans@umhcs.wrhs.org.au](mailto:Frank.Evans@umhcs.wrhs.org.au)  
Mary Hoodless Ph 0260763202 [Mary.Hoodless@umhcs.wrhs.org.au](mailto:Mary.Hoodless@umhcs.wrhs.org.au).

<b>Key Area #1 Management and Governance</b>					
	<b>Elements/Indicators (structures, resources processes, mechanisms)</b>	<b>Examples of achievement</b>	<b>How does your service achieve this element/indicator Include/list examples</b>	<b>Rating: LA, SA, EA, OA, N/A</b>	<b>Areas/strategies to e health promotion ca (optional)</b>
1.1	Health Promotion (HP) action & population health approaches are incorporated into the core business of the agency.	Health promotion (HP) is evident in or by the following processes: <ul style="list-style-type: none"> <li>• mission statement or organisational values;</li> <li>• corporate &amp; service planning processes;</li> <li>• staff professional development plan (staff training needs for health promotion are identified);</li> <li>• HP strategies respond to evidence of local health and well-being needs.</li> </ul>			
1.2	Appropriate proportion of resources are allocated to support health promotion action.	<ul style="list-style-type: none"> <li>• Resources assigned to health promotion. Eg. Positions, time, funded projects etc.</li> <li>• List how practitioners are aware of allocated funds &amp; how decisions are made around the distribution.</li> </ul>			

**Key Area #1 Management and Governance cont.**

	<b>Elements/Indicators (structures, resources processes, mechanisms)</b>	<b>Examples of achievement</b>	<b>How does your service achieve this element/indicator Include examples</b>	<b>Rating: LA, SA, EA, OA, N/A</b>	<b>Areas/strategies to e health promotion ca (optional)</b>
1.3	Executive positions have Health Promotion accountability	<ul style="list-style-type: none"> <li>• Managers understand &amp; value health promotion.</li> <li>• Management support and recognise the requirements of health promotion staff.</li> <li>• Health promotion outcomes appear in manager's performance agreements.</li> <li>• BOM understanding and support of Health Promotion</li> </ul>			
1.4	Health promotion action is incorporated into position descriptions & performance agreements at all levels of the organisation.	<ul style="list-style-type: none"> <li>• Health promotion is included in position descriptions and performance agreements.</li> </ul>			

**Key Area #1 Management and Governance cont.**

	<b>Elements/Indicators (structures, resources processes, mechanisms)</b>	<b>Examples of achievement</b>	<b>How does your service achieve this element/indicator Include examples</b>	<b>Rating: LA, SA, EA, OA, N/A</b>	<b>Areas/strategies to e health promotion ca (optional)</b>
1.5	There are systems that support service & organisational commitment to health promotion.	<ul style="list-style-type: none"> <li>• Structures such as health promotion committees exist.</li> <li>• Policies support health promotion decisions.</li> <li>• Municipal Health Promotion Committee</li> <li>• Community Advisory Group</li> <li>• OHS Committees</li> <li>• Networks</li> <li>• Service Planning</li> </ul>			
1.6	Senior managers are committed to and participate actively on steering committees for health promotion projects. BOM identify with and have a commitment to health promotion projects.	<ul style="list-style-type: none"> <li>• Senior managers participate on health promotion committees/projects</li> <li>• Senior managers bring issues, projects and feedback on HP activities to BOM agendas</li> </ul>			

**Key Area #1 Management and Governance cont.**

	<b>Elements/Indicators (structures, resources processes, mechanisms)</b>	<b>Examples of achievement</b>	<b>How does your service achieve this element/indicator Include examples</b>	<b>Rating: LA, SA, EA, OA, N/A</b>	<b>Areas/strategies to e health promotion ca (optional)</b>
1.7	Quality improvement systems for health promotion are in place	<ul style="list-style-type: none"> <li>• Best practice tools guide health promotion work eg. QICSA, competency based standards or capacity building indicators.</li> <li>• Evaluations of HP activities are conducted.</li> <li>• QA planning is incorporated into HP planning</li> </ul>			
1.8	Workplace health promotion planning processes.	<ul style="list-style-type: none"> <li>• Workplace health promotion strategies &amp; resources in place. Please list</li> </ul>			

<b>Key Area #2 Practitioners</b>					
	<b>Elements/Indicators (structures, resources processes, mechanisms)</b>	<b>Examples of achievement</b>	<b>How does your service achieve this element/indicator Include examples</b>	<b>Rating: LA, SA, EA, OA, N/A</b>	<b>Areas/strategies to e health promotion ca (optional)</b>
2.1	Health promotion activities are informed by evidence. (eg. Local evidence, research based evidence)	<ul style="list-style-type: none"> <li>• Evidence based health promotion strategies in place. List examples.</li> <li>• List sources of evidence</li> <li>• How do local needs translate into a HP activity?</li> </ul>			
2.2	Health promotion Intersectoral, interagency alliances and relationships exist.	<ul style="list-style-type: none"> <li>• Staff are part of multi disciplinary interagency health promotion committees and networks.</li> <li>• Staff participate on external and cross sector planning and action processes.</li> </ul>			

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<b>Key Area #2 Practitioners cont.</b>					
	<b>Elements/Indicators (structures, resources processes, mechanisms)</b>	<b>Examples of achievement</b>	<b>How does your service achieve this element/indicator Include examples</b>	<b>Rating: LA, SA, EA, OA, N/A</b>	<b>Areas/strategies to e health promotion ca (optional)</b>
2.3	Suitably experienced and qualified staff	<ul style="list-style-type: none"> <li>• Staff have relevant qualifications and skills</li> <li>• Information on health promotion courses &amp; conferences is disseminated to staff.</li> <li>• Staff development for health promotion available</li> <li>• Relevant access to journals/internet</li> <li>• Access to evidence based information.</li> </ul>			
2.4	Dedicated time for health promotion	<ul style="list-style-type: none"> <li>• Staff have time allocated for program planning, delivery and evaluation</li> </ul>			

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<b>Key Area #2 Practitioners cont.</b>					
	<b>Elements/Indicators (structures, resources processes, mechanisms)</b>	<b>Examples of achievement</b>	<b>How does your service achieve this element/indicator Include examples</b>	<b>Rating: LA, SA, EA, OA, N/A</b>	<b>Areas/strategies to e health promotion ca (optional)</b>
2.5	Health promotion reporting processes (intra-agency)	<ul style="list-style-type: none"> <li>• Documentation available to support HP programs</li> <li>• There are medical/program records for health promotion activities</li> <li>• Activities are reported in agency newsletters/media etc.</li> </ul>			
2.6	Opportunities for innovation and leadership in health promotion.	<ul style="list-style-type: none"> <li>• How are the staff supported &amp; acknowledged for dedication and leadership in HP. (This might also include mentoring, workforce development, workplace HP activities)</li> </ul>			

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<b>Key Area #3 Community</b>					
	<b>Elements/Indicators (structures, resources processes, mechanisms)</b>	<b>Examples of achievement</b>	<b>How does your service achieve this element/indicator Include examples</b>	<b>Rating: LA, SA, EA, OA, N/A</b>	<b>Areas/strategies to e health promotion ca (optional)</b>
3.1	Effective mechanisms for community participation in health promotion	<ul style="list-style-type: none"> <li>• Community members, user groups, support groups are involved in health promotion planning processes.</li> <li>• Needs of specific groups are responded to.</li> <li>• Staff are available to respond to community/individual requests for health promoting activities.</li> <li>• Community of interest is understood and recognised</li> </ul>			
3.2	Proven effective community participation in agency planning processes	<ul style="list-style-type: none"> <li>• Mechanisms exist for consumer participation in agency planning processes</li> </ul>			

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<b>Key Area #3 Community</b>					
	<b>Elements/Indicators (structures, resources processes, mechanisms)</b>	<b>Examples of achievement</b>	<b>How does your service achieve this element/indicator Include examples</b>	<b>Rating: LA, SA, EA, OA, N/A</b>	<b>Areas/strategies to e health promotion ca (optional)</b>
3.3	Community/consumer participation in health promotion policy development	<ul style="list-style-type: none"> <li>• Policies are distributed to consumers for comment and input.</li> </ul>			