# 'Partnerships for effective integrated health promotion'

## An analysis of impacts on agencies of the Primary Care Partnership Integrated Health Promotion Strategy'

**Final Report**

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**HDG Consulting Group**
With assistance from Effective Change Pty Ltd

Suite 1
206 Albert Street
East Melbourne VIC 3002
Contact:
Ro Saxon
Tel: 03 9416 0447
Email: ro.saxon@hdgconsulting.com.au

# Executive Summary

## The PCP IHP Strategy in Victoria

The Victorian Government initiated the Primary Care Partnership (PCP) strategy in 2000 to improve the health and well-being outcomes of people using primary health care services and to reduce avoidable use of hospital, medical and residential services. Over 800 service providers participate in the 31 PCPs which operate across Victoria.

PCPs focus on building relationships between agencies and service system reform. This includes better coordination of services and an integrated approach to health promotion and chronic disease management to provide better continuity of care, a more responsive system, and greater efficiency. The PCP platform is a highly developed network that engages different sectors and stakeholders. Utilising statewide demographic information and local knowledge to identify priority issues and difficult to reach population groups, a multi-sectoral integrated approach is used for planned Integrated Health Promotion (IHP).

The IHP strategy aims to strengthen the capacity of the health service system to plan, implement and evaluate health promotion initiatives that are robust and evidence-based. The IHP strategy includes effective cross-sector and inter-agency partnerships and the use of a common planning framework to identify, plan and implement a mix of targeted, catchment-wide health promotion interventions. The program logic for the PCP IHP Strategy describes the overall goal as being:

> *'To enhance wellbeing and quality of life, reduce the prevalence and incidence of disease, reduce the burden of illness/disability, and reduce health inequalities between population subgroups.'*

PCPs play a vital role in facilitating, planning and coordinating integrated health promotion. Through their PCP, individual agencies have the opportunity to collaborate in strategic and integrated health promotion planning and initiatives, to achieve shared goals of improved health outcomes for the community.

## What is integrated health promotion?

In Victoria, the term 'integrated health promotion' refers to agencies in a catchment working in a collaborative manner using a mix of health promotion interventions and capacity building strategies to address priority health and wellbeing issues. (DHS 2003) The IHP strategy aims to strengthen the capacity of the health service system to plan, implement and evaluate health promotion initiatives that are robust and evidence-based.

## Evaluation of the PCP IHP strategy

Whilst the overall PCP strategy was evaluated in 2003 and 2005 (AIPC), the Department of Human Services (DHS) commissioned an evaluation in June – September 2008 to report specifically on the impact of the IHP strategy on PCP member agencies.

The objectives of the evaluation were to:

- Inform DHS whether the PCP IHP strategy has been successfully meeting its stated objectives
- Establish the value, to the agencies sampled, of the partnerships model of IHP
- Inform DHS of the factors that are likely to impact upon successful application of the IHP strategy through PCPs
- Compile a comprehensive state–wide report on the current value of the PCP directed IHP strategy reported by a cross-section of targeted agencies.

The evaluation examined the role of partnerships in three key domains – the underlying partnership model and integrated planning approaches; IHP capacity building; and benefits, outcomes and continual improvement – and how these have contributed to successful integrated health promotion planning, implementation and evaluation for the agencies involved.

Data collection for the evaluation included semi-structured interviews, focus groups and a comprehensive questionnaire with a representative sample of PCP members, key stakeholder interviews and analysis of documentation including PCP community health plans.

Over 100 member agencies contributed to the evaluation. This included 80 participants from a cross-section of member agencies who provided information during nine focus groups with the PCP sample group; data provided on long-form questionnaires which were completed by 66 agencies and data provided on short-form questionnaires which were completed by 36 agencies.

A diverse range of service provider types were represented. Analysis of participation indicates the following representation by category as a percentage of all participants:

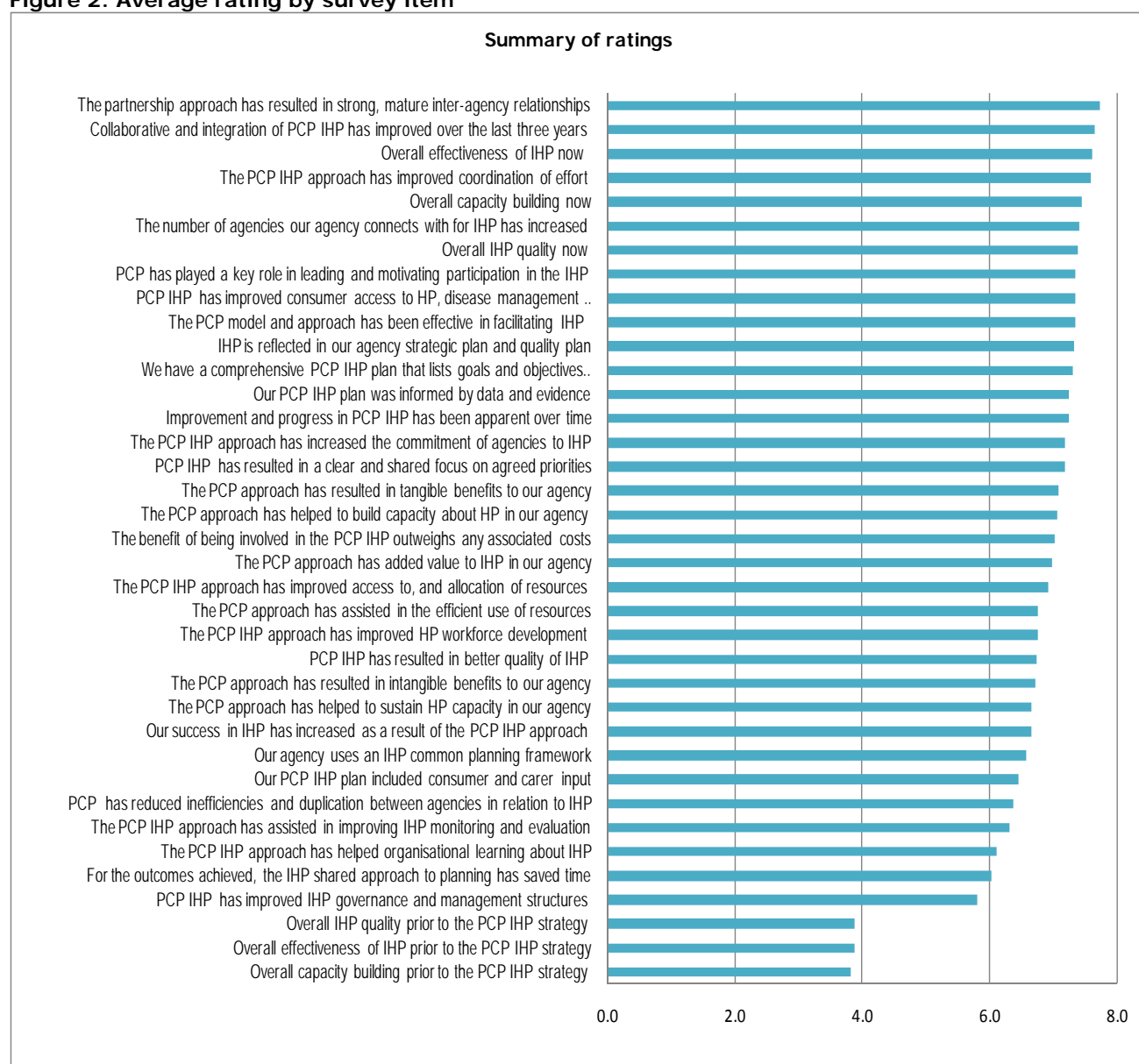**Figure 1: Evaluation participants by category**
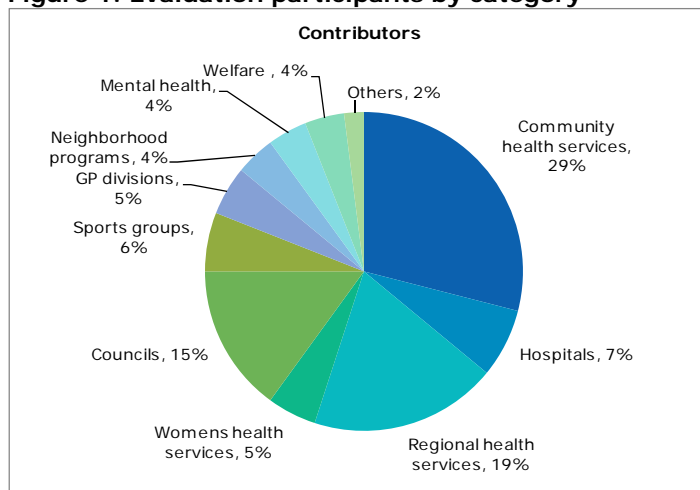
## What has the evaluation found?

Quantitative and qualitative evaluation data provides clear evidence of the success of the partnership approach to improved IHP. A significant increase in the overall quality and effectiveness of IHP from before the introduction of the PCP IHP strategy to the current time was evident. Key findings are that the PCP approach to IHP has clearly:

- demonstrated an improvement in integrated planning
- demonstrated an increase in organisational capacity for health promotion
- demonstrated economic and other benefits to member agencies
- contributed to healthier communities.

**Figure 2: Average rating by survey item**



Summary of ratings

The partnership approach has resulted in strong, mature inter-agency relationships
Collaborative and integration of PCP IHP has improved over the last three years
Overall effectiveness of IHP now
The PCP IHP approach has improved coordination of effort
Overall capacity building now
The number of agencies our agency connects with for IHP has increased
Overall IHP quality now
PCP has played a key role in leading and motivating participation in the IHP
PCP IHP has improved consumer access to HP, disease management ..
The PCP model and approach has been effective in facilitating IHP
IHP is reflected in our agency strategic plan and quality plan
We have a comprehensive PCP IHP plan that lists goals and objectives..
Our PCP IHP plan was informed by data and evidence
Improvement and progress in PCP IHP has been apparent over time
The PCP IHP approach has increased the commitment of agencies to IHP
PCP IHP has resulted in a clear and shared focus on agreed priorities
The PCP approach has resulted in tangible benefits to our agency
The PCP approach has helped to build capacity about HP in our agency
The benefit of being involved in the PCP IHP outweighs any associated costs
The PCP approach has added value to IHP in our agency
The PCP IHP approach has improved access to, and allocation of resources
The PCP approach has assisted in the efficient use of resources
The PCP IHP approach has improved HP workforce development
PCP IHP has resulted in better quality of IHP
The PCP approach has resulted in intangible benefits to our agency
The PCP approach has helped to sustain HP capacity in our agency
Our success in IHP has increased as a result of the PCP IHP approach
Our agency uses an IHP common planning framework
Our PCP IHP plan included consumer and carer input
PCP has reduced inefficiencies and duplication between agencies in relation to IHP
The PCP IHP approach has assisted in improving IHP monitoring and evaluation
The PCP IHP approach has helped organisational learning about IHP
For the outcomes achieved, the IHP shared approach to planning has saved time
PCP IHP has improved IHP governance and management structures
Overall IHP quality prior to the PCP IHP strategy
Overall effectiveness of IHP prior to the PCP IHP strategy
Overall capacity building prior to the PCP IHP strategy

0.0    2.0    4.0    6.0    8.0

Scale: Statements rated by participants from 1 = low, disagree to 10 = high, agree

- ***Integrated planning has improved***

The evaluation gathered significant qualitative and quantitative evidence that demonstrated the PCP IHP approach has improved the level and comprehensiveness of integrated planning between member agencies within a PCP.  Evidence for this includes the increasing maturity of partnerships and quality improvement in planning processes.  The evaluation findings indicate that IHP has become increasingly effective over time as PCP leadership has enabled network relationships to broaden and mature, resulting in reported increased IHP member agency breadth, capacity and sustainability over time.

PCP member agencies reported that the breadth (ie. number of member agencies), diversity (ie. different types of agencies) and depth (ie. knowledge about each agency) of their networks had increased as a result of the partnership model and approach.  Through this extension of partnerships, and the inclusion of smaller and new agencies, the breadth of the PCP health promotion focus had expanded.

Evaluation data indicated that the partnership model has, over time, engendered a culture and inherent acceptance that in many (but not all) instances, a partnership approach was the preferred approach to integrated health promotion.  This finding suggests that the concept of partnerships and collaboration is now the accepted every-day approach to integrated health promotion for most member agencies.  In most PCPs the view of the participating agencies was that the prevailing culture of partnerships, as supported by the PCP IHP approach, was both expected and beneficial.

The evaluation data also indicated that PCP IHP networks, planning processes and meeting routines meant that member agencies were clear about roles, responsibilities, timelines and how they could best contribute to integrated planning.  The outcome of these improved planning structures and processes was that IHP was considered to be more strategic – with more targeted and directed effort which in turn resulted in a focussed health promotion effort to achieve greater impact.  Whilst planning processes had become less duplicitous and more streamlined over time, a key area for improvement was identified as the nexus between local government planning requirements, organisational or funding body planning requirements and IHP planning.

Agencies reported that the integrated health promotion plans were informed by an analysis of data from a range of sources, including international, national and state policy documents, state and local data sets and participation of consumers and community members.  Document analysis of PCP Community Health Plans indicated an increased use of evidence and data over time.  There was an overall improvement in the use of data and evidence to establish integrated health promotion priorities.

Overall, agencies noted that in the early years of PCPs a significant amount of time was invested in the development of a strong foundation for inter-agency relationships, and that these had now matured to the point where the investment was generating benefits.  Three key measures – that success in IHP had increased as a result of the PCP IHP approach; that collaboration and integration of PCP health promotion had improved over the past three years; and, that the PCP IHP approach had resulted in a clear and shared focus on agreed priorities – provide clear evidence that the PCP IHP approach has been a key facilitator in improved integrated planning and the success of IHP.

- ***Organisational capacity for health promotion has increased***

A key finding of the evaluation was that successful partnerships were a catalyst for building health promotion capacity in organisations. One way this has been achieved was through the development of skills, knowledge and learning within organisations. Evaluation findings indicate that the statewide PCP IHP approach has created a virtual knowledge bank in relation to the health of local communities and health promotion strategies.

Agencies reported that PCPs had a key role in leading and motivating participation in IHP and that this resulted in an increased awareness about health promotion within organisations. They perceived the PCP leadership role as being continually building capacity to respond to health priorities in the catchment.

At an organisational level, capacity was sustained through continuing senior leadership representation at executive level of the PCP and agency policies and procedures reflecting integrated health promotion, the inclusion of health promotion in staff position descriptions, meeting agendas, policy documents and training and orientation programs within member agencies. The evaluation found that the PCP IHP strategy had clearly improved organisational capacity for IHP.

- ***Economic and other benefits are evident***

As a result of their involvement in integrated health promotion, individual agencies have much to gain. The evaluation found that the PCP IHP approach generates multiple tangible and intangible benefits for member agencies. The benefits of being involved in the PCP IHP were considered to outweigh the cost for member agencies. Whilst a minority of agencies were ambivalent about the value added, the qualitative and quantitative data indicated that the majority of agencies believed that the PCP approach had added value to IHP in their agency. In areas where partnerships were considered effective, there were tangible benefits, such as improved access to financial resources, increasingly efficient use of resources and IHP training for agency staff.

Agencies reported that PCP IHP had impacted on resource identification and allocation in two key ways. Firstly, the PCP was a platform for distribution of selective DHS funding; and secondly, the PCP could identify new potential financial resources. Both of these roles were considered important in terms of access to and effective and efficient use and distribution of funds. The agreed and consistent process of consulting with members, identifying leaders and other stakeholders and providing input to funding submissions was considered to have made the process more effective than it was in the past. The environment of mutual responsibility and consolidated effort had reduced duplication and contributed towards efficiencies and greater outcomes from finite resources. In addition, the PCP IHP approach was considered as a protective strategy in terms of guarding agency health promotion resources from dilution due to competing agency priorities. Overall, the approach enabled individual agencies to leverage the collective knowledge, skills and to some extent, resources, of the partnership to benefit the community.

Three key measures – that the PCP IHP approach had improved access to, and allocation of IHP resources; that the PCP approach had assisted member agencies in the efficient use of resources; and, that the PCP approach had reduced inefficiencies and duplication between agencies in relation to IHP - together provide evidence that the PCP IHP approach has had a positive impact in terms of the efficiency of IHP resource allocation and use.

The majority of member agencies perceived the investment of time and effort in IHP generated positive outcomes and a reasonable return on their investment.  Direct, tangible benefits, combined with benefits arising from more efficient and effective processes, and access to knowledge and skills of other organisations, generally make integrated health promotion an attractive approach for agencies.

- *PCP IHP contributes to healthier communities*

Evaluation data indicates that the PCP IHP strategy had benefited local communities through the increased capacity and ability of member agencies to implement health promotion activities.  A more planned and coordinated approach built on a stronger evidence base resulted in health promotion initiatives being better targeted to addressing local health priorities.  Several PCPs commented on evaluations that were occurring for local IHP initiatives.  There was also a growing understanding within agencies of how the work of the PCP can benefit the community through links between health promotion, early intervention in chronic disease programs and service coordination.

**Conclusion**

The evaluation found that the PCP IHP strategy is valued and effective.  Member agencies reported a dramatic increase (almost double) in the overall effectiveness of IHP from prior to the PCP IHP strategy to the current time.  Likewise, a substantial increase in the overall quality of IHP before and after the PCP IHP strategy was evident.  These evaluation findings provide robust evidence of the success of the partnership approach to IHP and the impact of the PCP IHP strategy (Figures 3 and 4).
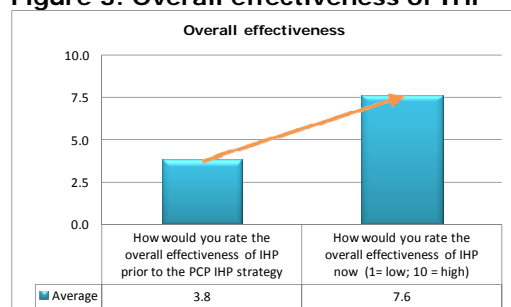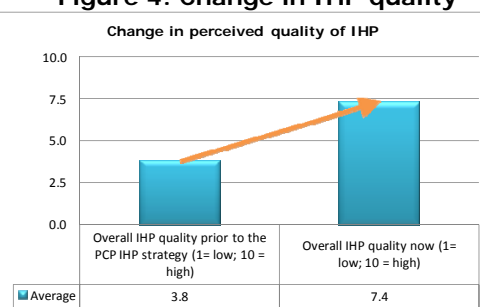
**Figure 3: Overall effectiveness of IHP**      **Figure 4: Change in IHP quality**



| Overall effectiveness | | Change in perceived quality of IHP | |
|---|---|---|---|
| How would you rate the overall effectiveness of IHP prior to the PCP IHP strategy | How would you rate the overall effectiveness of IHP now  (1= low; 10 = high) | Overall IHP quality prior to the PCP IHP strategy (1= low; 10 = high) | Overall IHP quality now (1= low; 10 = high) |
| Average  3.8 | 7.6 | Average  3.8 | 7.4 |

Successful application of the IHP strategy through PCPs was influenced by numerous factors.  Enabling factors were: a common purpose, effective communication and clarity about roles and relationships; positive attitudes by stakeholders about IHP and by member agencies towards the PCP and each other; policy, planning and resources supportive of IHP; and effective IHP skills and leadership demonstrated by the PCP.

The PCP IHP strategy has acted as a catalyst for capacity building. It has generated a virtual wealth of IHP knowledge and skills with a resultant increase in IHP quality. Over the eight years since the introduction of the PCP IHP strategy, the analysis of impacts on member agencies suggests that the strategy has been a powerful and effective way of strengthening integrated health promotion. Overall, there was clear recognition within member agencies that the IHP approach is credible, is perceived as a positive investment and is valued for the multiple benefits it generates.

**Recommendations**

The PCP IHP strategy has generated a range of outcomes at a systemic, catchment, local community, agency and logically, consumer level. Continued implementation of the strategy will continue to build the capacity of organisations to plan and deliver integrated health promotion to contribute to positive health outcomes for the community. Based on the evaluation findings, a series of recommendations have been developed to inform ongoing implementation of the PCP IHP strategy.

1. Engage key stakeholders

   1.1 That DHS, PCPs and agencies promote commitment to PCP IHP at the senior leadership level.

   1.2 That DHS, PCPs and agencies engage community members in a planned way.

2. Streamline planning

   2.1 That DHS continues to work towards more streamlined planning and reporting processes.

3. Continue investment in workforce development

   3.1 That further investment in IHP workforce development is embraced by all parts of the sector.

   3.2 That agencies invest in IHP skills development for staff.

   3.3 That the development and acquisition of evaluation skills continues to be promoted.

4. Strengthen evaluation and quality improvement

   4.1 That regular evaluation of the partnership is undertaken.

   4.2 That achievements, impacts and outcomes are collated and analysed.

5. Focus on tangible benefits

   5.1 That tangible benefits for member agencies are identified, measured and results disseminated.

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## 1.1    Context

The Victorian Government initiated the Primary Care Partnership (PCP) strategy in 2000 to improve the health and well-being outcomes of people using primary health care services and to reduce avoidable use of hospital, medical and residential services.  Over 800 service providers participate in the 31 PCPs which operate across Victoria.

PCPs focus on building relationships between agencies and service system reform.  This includes better coordination of services and an integrated approach to health promotion and chronic disease management to provide better continuity of care, a more responsive system, and greater efficiency.  The PCP platform is a highly developed network that engages different sectors and stakeholders.  Utilising statewide demographic information and local knowledge to identify priority issues and difficult to reach population groups, a multi-sectoral integrated approach is used for planned Integrated Health Promotion (IHP).

The IHP strategy aims to strengthen the capacity of the health service system to plan, implement and evaluate health promotion initiatives that are robust and evidence-based. The IHP strategy includes effective cross-sector and inter-agency partnerships and the use of a common planning framework to identify, plan and implement a mix of targeted, catchment-wide health promotion interventions.  The program logic for the PCP IHP Strategy describes the overall goal as being:

> *'To enhance wellbeing and quality of life, reduce the prevalence and incidence of disease, reduce the burden of illness/disability, and reduce health inequalities between population subgroups.'*

Whilst the overall PCP strategy has been evaluated (AIPC 2003, 2005) this evaluation was specific to the IHP strategy.  The evaluation provides an opportunity to determine the extent to which the IHP strategy is meeting its stated objectives, with a specific focus on the impact of the strategy on member agencies' health promotion activities.  It is important to note that it does not evaluate or report on the outcome of IHP interventions, but rather was focused on the benefits and value of the partnership model to member agencies.

## 1.2    Objectives

The objectives of the evaluation were to:

- Inform DHS whether the PCP IHP strategy has been successfully meeting its stated objectives
- Establish the value, to the agencies sampled, of the partnerships model of IHP
- Inform DHS of the factors that are likely to impact upon successful application of the IHP strategy through PCPs
- Compile a comprehensive state–wide report on the current value of the PCP directed IHP strategy reported by a cross-section of targeted agencies.

## 1.3    Evaluation method

HDG Consulting Group was commissioned to conduct the evaluation which occurred between May and August 2008.  Based on a detailed evaluation plan (Appendix 1), the agreed evaluation method focussed on the impact of the PCP IHP strategy on member agencies in three key areas:

1. Partnership model and integrated planning
2. Capacity building
3. Benefits, outcomes and continual improvement.

These domains were selected for evaluation as they reflect the key conceptual elements underpinning the PCP IHP approach and the evaluation objectives.  The rationale for the selection of each of the three domains is outlined below.

*Partnership model and integrated planning*

Quality health promotion practice requires integrated approaches and partnerships.  Partnerships are the central premise on which PCPs are based – the belief that partnership approaches between agencies can harness and coordinate collective efforts to achieve improved overall outcomes.  The importance of partnership models is increasingly evident in literature and has underpinned the PCP strategy since its inception.  Integrated health promotion plans developed by each partnership outline the strategies for the partnership's catchment area and population – this is central to PCP IHP program logic.

*Capacity building*

The ability to build capacity and implement programs is central to the PCP IHP program logic.  Capacity building is defined by Hawe et al., (2000) as the development of sustainable skills, organisational structures, resources and commitment to health improvement in health and other sectors.  Key dimensions for capacity building change actions are identified as organisational development, workforce development, resource allocation, partnerships and leadership.

*Benefits, outcomes and continual improvement*

Whilst previous evaluations identified that the PCP IHP strategy has positive benefits for member agencies, there is the need for these to be further investigated and identified.  Benefits to member agencies may be tangible or intangible – and the evaluation provides the opportunity to explore this.  Information from this domain will be linked to another project designed to develop specific PCP IHP measures.  An ongoing focus on continual improvement is fundamental to best practice service planning, delivery and management.  Quality standards rely on the ability to identify and respond to continuous improvement cycles, hence the evaluation should investigate further improvements to enhance positive outcomes in future.

In accordance with the evaluation objectives, a cross-section of PCPs with a range of different characteristics was identified for data collection.  A purposive sample group of nine PCPs and their member agencies were selected to provide detailed information.

Data collection methods included:

- Semi- structured interviews and focus groups with senior managers or middle managers from member agencies. These forums provided the opportunity to consider and discuss the complexities of the local partnerships and the way in which they had supported the implementation of IHP. Participants were also asked to comment on the benefits and value they received as a result of their investment in the partnership and how this impacted on their agency and its ability to implement IHP initiatives.
- Broad level consultation and semi-structured interviews with other government departments, peak bodies and other relevant stakeholder groups.
- A comprehensive questionnaire for agencies in the sample group as well as a shorter questionnaire for agencies from non-sample group PCPs.
- Analysis of written reports from health promotion projects and PCP community health plans.

Over 100 member agencies contributed to the evaluation. This included 80 participants from a cross-section of member agencies who provided information during nine focus groups with the PCP sample group; data provided on long-form questionnaires which were completed by 66 agencies and data provided on short-form questionnaires which were completed by 36 agencies. A diverse range of service provider types were represented. Analysis of participation (in focus groups and via long and short form questionnaires) indicates the following representation by category as a percentage of all participants:

- Community Health Services 29%
- Regional Health Services 19%
- Local government 17%
- Hospitals 7%
- Womens Health Services 5%
- GP Divisions 5%
- Sports groups 6%
- Neighbourhood programs 4%
- Mental Health Services 4%
- Welfare services 4%
- Other 2%.

## 1.4    Report structure

This report presents the results of the evaluation. Sections 2 to 5 of the report are structured to reflect the key findings and themes arising from the synthesis and analysis of review data. Each section of the report represents a key theme and includes both qualitative and quantitative evidence to support the findings. Case studies have been included to highlight key concepts for each of the selected themes. Data for individual PCPs has not been reported separately in these chapters as a comparison of the performance of individual PCPs was not an objective of the evaluation. The intention of the evaluation was to provide a comprehensive statewide view of the value of the IHP partnerships based on the experience of the sample group of agencies.

While many of the key enablers of successful PCP IHP identified by member agencies are incorporated throughout sections 2 to 5 of the report, section 6 lists additional enabling factors as well as barriers identified from focus groups, questionnaires and key informant interviews. Success factors and opportunities for continuous improvement are also described in section 6.

Section 7 concludes the report with a summary of key evaluation findings, commentary about the effectiveness and value to member agencies of the PCP IHP strategy and recommendations arising from the outcomes of the evaluation.

# 2    Integrated planning has improved

The evaluation gathered significant qualitative and quantitative evidence to demonstrate that the PCP IHP approach has improved the level and comprehensiveness of integrated planning between member agencies within a PCP.  This was demonstrated through the increasing maturity of partnerships and improvements in the quality of planning processes.  The data indicated that integrated planning has improved as a direct result of the PCP IHP approach.

## 2.1    Increasing partnership network breadth and diversity

Agencies reported that the breadth (ie. number of member agencies), diversity (ie. different types of agencies) and depth (ie. knowledge about each agency) of their networks had increased as a result of the partnership model and approach.  Analysis of questionnaire results provided a statewide average rating for this item of 7.5 out of 10, indicating a high level of agreement that the partnership approach had resulted in an increase in the number of agencies (Figure 5).  For example, in one PCP, membership had grown from 25 to 45 agencies, thus almost doubling the breadth of agency contacts for individual member organisations within a three year period.

Document analysis of PCP Community Health Plans from the planning periods 2004-06 and 2006-09, indicated that in the majority of cases the number of agencies participating in planning and implementation of IHP had increased.  There was the option for agencies to be involved in working groups or as affiliated members.  PCP IHP participation included health services, community health, divisions of general practice, women's health and aged care agencies.  More broadly, most but not all PCP's included aboriginal health, mental health, family and other welfare services, Vision Australia and RDNS.  Some included housing, disability, CALD, agencies, sports assemblies, Department of Veteran's Affairs, neighbourhood houses (the latter three were more prominent in rural areas).

Agencies reported that the partnerships facilitated communication and involvement with agencies that they would not otherwise have had contact with, due to time or resourcing issues.  Through this extension of partnerships, and the inclusion of smaller and new agencies, the breadth of the PCP health promotion focus had expanded.  Agencies reported that the partnership approach had enabled a move away from ad hoc networks based on personal connections to a coordinated approach.  The round-table, inclusive nature of the partnerships provided a time-efficient mechanism by which communication and contact could occur.  This was particularly the case for smaller agencies which, prior to PCP IHP, were limited, by virtue of time available, in the number of other agencies they could liaise with.  Thus, for smaller agencies, the approach provided access to a broad, cross-sector range of service providers in a time efficient manner.  For example, one small disability agency in an isolated rural community expressed that without the PCP IHP approach almost all of their interaction would be within the disability sector.  Access to the PCP provided an easy means of accessing a broader range of agencies and addressing a wider range of client needs.

Likewise, some other government departments and peak bodies commented that the PCP IHP partnership model provided access to a large number of agencies.  For example, one agency commented that the PCP IHP platform had been 'incredibly useful for accessing agencies and agreeing policy priorities' on a statewide basis.  Another peak organisation commented that the PCP IHP structure provided an excellent opportunity mechanism to raise awareness of the needs of specific population subgroups.  'Having a place at the PCP table in each region' provided the opportunity to make presentations at member meetings and create a much higher level of awareness than trying to advocate to individual agencies.  Several PCPs noted that there was significant potential to further extend relationships with a range of government departments and agencies beyond the core health and community services system.  These links would support a broader approach to addressing all of the determinants of health and well being.
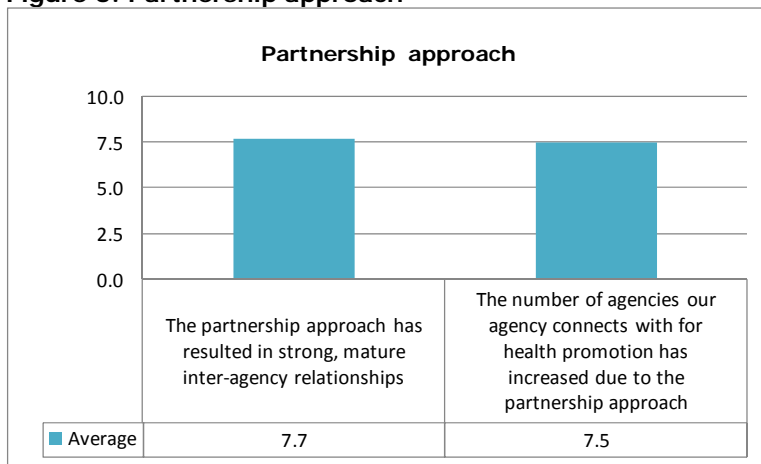
## 2.2 Maturing of inter agency relationships

Agencies reported that inter-agency relations had matured as a result of the partnership approach. By virtue of partnership structures and processes (e.g. meetings, planning, projects), relationships had matured. Analysis of questionnaire results provided a statewide average rating for this item of 7.7 out of 10, indicating a high level of agreement with the statement that the PCP IHP approach had contributed to more mature relationships (Figure 5). This increased level of trust between agencies was demonstrated through the sharing of knowledge, equipment and other resources across agencies.

> *'Whatever we say we are going to do we do it...This builds trust and agencies start to see the benefits of being involved and have started to take more ownership of the PCP.'* (Focus group participant)

However, in some locations, participants felt that the partnership approach had not progressed to the stage that a mature partnership could achieve and that there was potential for further growth. Reasons for this included communication issues, leadership style, workforce turnover, policy and funding barriers or enablers, and a sense of not realising benefits from the partnership.

Overall, agencies noted that in the early years of PCPs a significant amount of time was invested in the development of a strong foundation for these inter-agency relationships, and that these had now matured to the point where the investment was generating benefits. The benefits of mature relationships were seen as trust, cooperation and mutual benefit, which in turn facilitated effective and efficient decision making and positive outcomes.

**Figure 5: Partnership approach**



| | The partnership approach has resulted in strong, mature inter-agency relationships | The number of agencies our agency connects with for health promotion has increased due to the partnership approach |
|---|---|---|
| Average | 7.7 | 7.5 |

## 2.3 Partnership culture and expectations

Evaluation data indicated that the partnership model has, over time, engendered a culture and inherent acceptance that in many (but not all) instances, a partnership approach was the preferred approach to integrated health promotion. Analysis of questionnaire free text and focus group narrative provided evidence that there was an acceptance that partnerships would be considered as a matter of course, and that communication with, and involvement of the partnership was a key strength in terms of achieving positive outcomes. Analysis of questionnaire results provided a statewide average rating for this item of 7.4 out of 10 indicating that the partnership approach was considered effective in facilitating IHP (Figure 5). This suggests that the concept of partnerships and collaboration is now the accepted every-day approach to integrated health promotion.

> *'Health Promotion has taken off in this area and it is largely due to the leadership of the PCP.'* (Focus group participant)

Document analysis of PCP Community Health Plans from the planning periods 2004-06 and 2006-09, showed evidence of the development of shared leadership and collaboration. More recent plans identified lead agencies and partner agencies in different strategies as well as resource commitment from multiple agencies.

Whilst the majority of feedback indicated that the partnership culture underpinning integrated health promotion approach was considered essential, some respondents commented that this was only partially due to the PCP model and that there remained inherent tensions, particularly in areas where member agencies considered the PCP less successful. However, in most PCPs the view of the participating agencies was that the prevailing culture of partnerships, as supported by the PCP IHP approach, was both expected and beneficial.

## 2.4    From competition to collaboration and commitment

Member agencies commented how relationships had developed over time from a situation where agencies had to compete for health promotion funding to the current situation where agencies have a clear understanding of the benefits of collaboration. Agencies are conscious of their respective roles and strengths, and are able to share leadership and make joint decisions about which agencies are best suited to carry out particular components of the work. Agencies cited numerous examples where PCP members had cooperated in the development of funding submissions. Some agencies expressed that the PCP IHP approach had given them 'permission' to work collaboratively when they previously had been uncertain whether a partnership approach was appropriate.

Evaluation data indicated that the partnership approach has enabled catchment-wide planning across programs, sectors and stakeholders, resulting in an increased number of agencies collaborating to address local health issues. As a result of having more agencies involved, the breadth and capacity to plan, develop and implement health promotion had increased. For example, the breadth of health promotion in local areas had broadened through the inclusion of organisations representing multiple sectors, such as other government departments or sporting associations. The collaboration allowed smaller agencies and those with a specific advocacy role, to promote the needs of their communities and to influence other agencies' planning (e.g. culturally specific agencies, Women's Health).
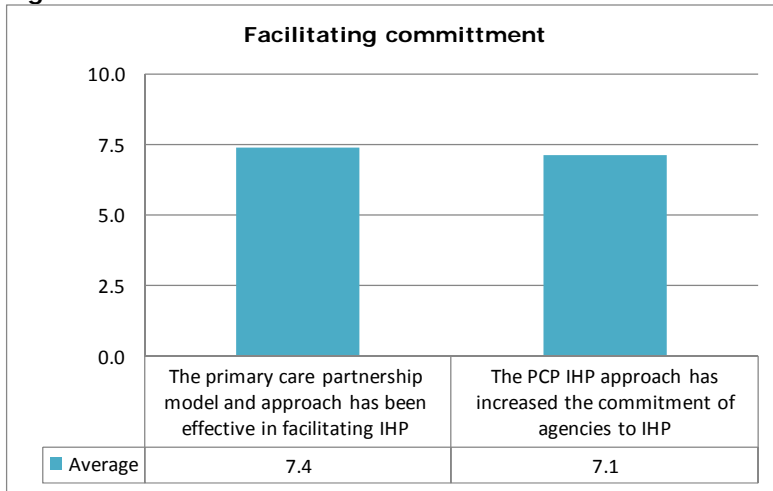
Agencies reported that the collaborative approach had resulted in a better knowledge and understanding of the roles and activity of other agencies, and this was highly valued. With this understanding came a higher level of responsiveness to funding opportunities, as the relevant agencies to be involved in a project were quickly identified and involved in making applications for health promotion initiatives.

> *'Working with the PCP has allowed our agency to build partnerships with agencies in a more cost effective and time efficient manner than we would otherwise have been able to. We are working with community houses on Men's shed programs that we wouldn't have known existed without the PCP's IHP.'* (Questionnaire respondent)

Evaluation data indicated that the PCP approach has been effective in both facilitating IHP and increasing agency commitment to IHP. During a focus group, member agencies in one PCP described the level of commitment as having grown to a 'shared distribution' approach where the agencies were encouraged to work together and 'share the spoils' when project funding became available. Agencies had become accustomed to alternating in taking leadership for projects or for fund holding. In the view of member agencies, the PCP had been 'very good at facilitating this process.'

Analysis of questionnaire results provided a statewide average rating for this item of 7.4 out of 10 for effective facilitation of IHP and 7.1 out of 10 for increasing commitment to IHP (Figure 6). These findings indicate that the PCP IHP approach has impacted positively on the ability of agencies to deliver IHP outcomes and was effective in increasing the commitment of agencies to integrated health promotion.

**Figure 6: Facilitation and commitment**

**Facilitating committment**

| | The primary care partnership model and approach has been effective in facilitating IHP | The PCP IHP approach has increased the commitment of agencies to IHP |
|---|---|---|
| Average | 7.4 | 7.1 |

## 2.5    Strengthened planning structures and processes

Planning structures and processes were considered to have improved over time as a result of the PCP IHP approach. PCP planning structures typically included a Health Promotion Working Group (or similar) with other, more targeted working groups established in response to specific priorities and initiatives. In some PCPs, each priority area had an action group responsible for carrying out and reporting on the strategies identified in the plan. For example, one PCP has action groups in mental health, physical activity and nutrition. The action group structure meant that staff could participate in the groups most relevant to their work. A benefit of this approach for smaller agencies was that it enabled them to connect with a network and participate in implementation, even if they were not specifically funded for health promotion.

In its 2007 report Promoting Better Health Through Healthy Eating and Physical Activity, the Victorian Auditor-General observes that one of the positive steps taken by the Department of Human Services (DHS) and other agencies has been to help local agencies improve their health promotion planning by providing best practice frameworks and assisting them to apply these. The report notes the need to strengthen the evidence base used to guide and refine the State's investment in health promotion and the planning and coordination of programs across government. (p. 2)

A comparison of a sample of Community Health Plans over time revealed that most of the PCPs had built on learnings from earlier planning cycles and made improvements such as establishing a planning reference group, using networks and working groups, building in planning review cycles, using a priority setting matrix, linking with municipal health plans, building on catchment planning and establishing an evaluation framework.

The development of robust communication channels between agencies has contributed to the development of quality plans and the ability to address particular health promotion priorities.

> *'It's easy to get linked in with other agencies and programs, to understand the bigger picture of local health issues and to learn about health promotion concepts and principles from the other members.'* (Focus group participant*)*

Evaluation data indicated that PCP IHP networks, planning processes and meeting routines meant that member agencies were clear about roles, responsibilities, timelines and how they could best contribute to integrated planning.

> *'[Prior to PCP IHP] ..We struggled to plan and implement health promotion projects effectively, however now we are able devise a plan based on what the community needs not what we think they need, and we have gained skills to implement successful health promotion post-PCP involvement.  They have given us direction, skills and knowledge.'*  (Questionnaire respondent)

The outcome of these improved planning structures and processes was that IHP was considered to be more strategic – with more targeted and directed effort which in turn resulted in a focussed health promotion effort to achieve greater impact.

> *'Integrated planning has facilitated a more strategic population focus for health promotion work…it is producing better outcomes for citizens'.*  (Focus group participant)

## 2.6    Common planning framework

Integrated planning is supported by the common planning framework described in the *Integrated health promotion resource kit* (2003) produced by DHS.  Agencies reported that the PCP IHP approach had enabled a more coordinated and well planned approach to health promotion planning.  Integrated health promotion had an increasing profile and was reflected in strategic and quality plans for individual agencies.

Analysis of questionnaire results provided a statewide average rating for use of a common planning framework of 6.6 out of 10.  Apart from integrated catchment-wide planning, respondents had used the IHP resource kit within their agency for a variety of purposes such as:

- a reference guide for planning, design and evaluation of internal health promotion activities
- a tool for developing plans and funding applications
- a reference tool for providing an introduction to health promotion principles to new and existing staff.

PCP IHP planning provided information to assist in the interface between plans such as Community Health Plans, Local Government Municipal Public Health Plans and Divisions of General Practice Health Promotion Plans.  The PCP IHP approach assisted member agencies to focus on agreed priority areas or cohorts (for example, mental health or indigenous health) and address them in a coordinated manner.  The focus on shared priorities and capacity building, within the context of each organisation's own planning requirements, served to provide a shared focus whilst bridging specific agency planning requirements.

Participants also commented that the integrated planning process forced them to think about the bigger picture and to forge links outside their own 'patch'.  Many participants agreed that there were some benefits in having a common strategic plan that reflected the goals of all the agencies within the PCP.
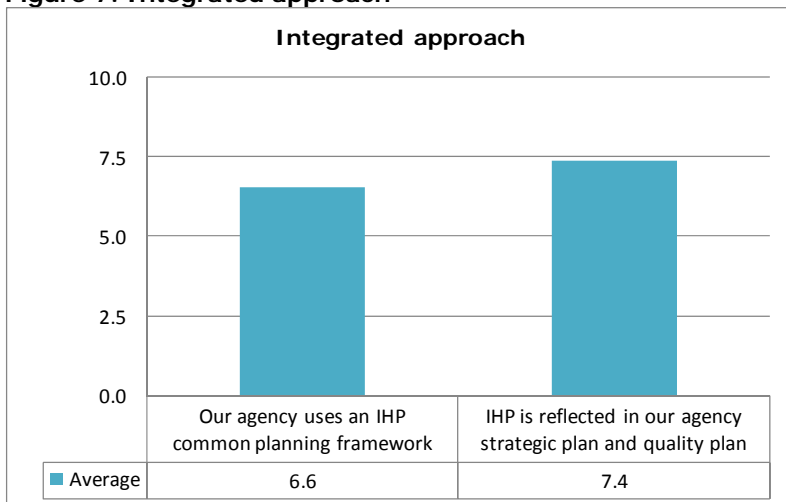
Feedback from a government department indicated that having a framework for health promotion planning had provided 'better theory about how you design a program in this area' and that having a ready-made framework was a 'cost saving' opportunity.

Whilst feedback about the common planning framework and process was generally positive, a degree of frustration was reported with the number of plans that were required and the level of duplication. For example, some agencies that participated in the PCP IHP Plan, also were required to develop individual agency IHP plans. Whilst some elements of these plans were common (and could be copied across each) there was a perceived duplication of effort. Local government representatives indicated that the Municipal Public Health Plan was the key planning tool for local government and was a legislated requirement which could not be replaced by the PCP IHP Plan. Development of the PCP IHP Plan was thus viewed as a duplication of effort. The timing variation in planning cycles also presented a challenge.

Some respondents suggested that clear guidance from DHS would assist in clarifying the differences between the PCP planning processes and the individual agency planning. Others felt that the planning process may result in more actions if the PCP plan was focused on a smaller number of projects or goals and encouraged action around those rather than being an 'all encompassing plan'.

Whilst planning in an integrated way remained challenging due to the different agency and funding stream planning cycles and requirements, IHP was increasingly reflected in agency strategic and quality plans, with a statewide average rating for this of 7.4 out of 10.

**Figure 7: Integrated approach**



| | Our agency uses an IHP common planning framework | IHP is reflected in our agency strategic plan and quality plan |
|---|---|---|
| ■ Average | 6.6 | 7.4 |

## 2.7   Improved quality of health promotion planning

Agencies reported that the quality of health promotion planning had improved with each of the planning cycles. The initial plans (2003-2006) were considered comprehensive but without rigorous data, whereas more recent plans were considered to be much more robust and based on available evidence. Participants also believed that increased knowledge and experience with IHP over several years had contributed to the improvement in the quality of plans.

Some of the improvements noted in comparing current Community Health Plans with earlier plans were in the breadth of input from agencies, the identification of priorities based on local data and consultation and the identification of roles, responsibilities and resources. There was also evidence of use of VicHealth Partnerships Tool (VicHealth, 2003), Quality Improvement Planning System (QIPPS) and evaluation tools being used.
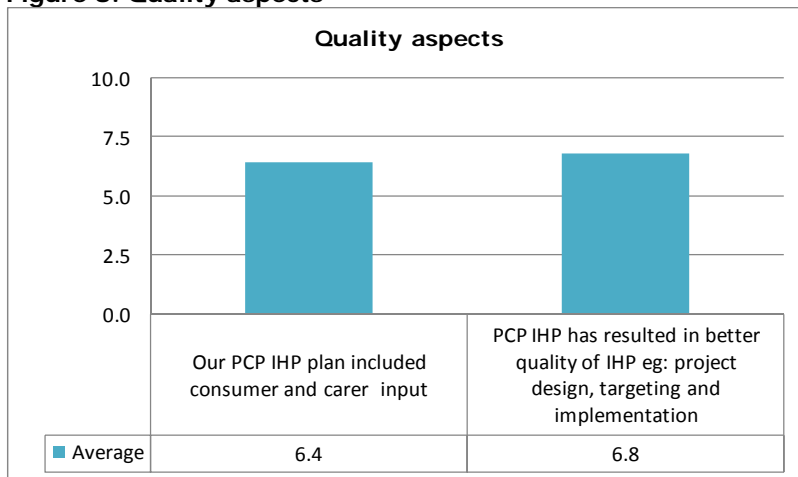
Some participants suggested that the improved quality of planning reflected:

- The use of high quality data and evidence
- A broader perspective of community needs (e.g. In one PCP, research into food security and availability had built capacity in services beyond health)
- An increased ability of consumers to advocate for their own needs achieved through various initiatives (e.g. advocacy workshops for Mothers Living Well, Consumer Reference Groups)
- An increased focus on monitoring and evaluation. Members in one PCP saw that evaluation had become a 'big part of life'.

Analysis of questionnaire results provided a statewide average rating for this item of 6.8 out of 10, indicating that the PCP IHP approach had resulted in improved IHP quality.

Evaluation data indicated that a key area for improvement was the input by consumers and carers to the planning process, with the item rated as 6.4 out of 10. Individual PCPs that had clear processes for consumer engagement and input to planning processes, felt that the provision of support for consumer participation, including the policy of reimbursing community members for participating in consultations, was one of the partnership's strengths. Agencies commented about *Consumer Advisory Groups and Guidelines for Community Participation* and how these had assisted to facilitate community involvement.

**Figure 8: Quality aspects**



| | Our PCP IHP plan included consumer and carer input | PCP IHP has resulted in better quality of IHP eg: project design, targeting and implementation |
|---|---|---|
| Average | 6.4 | 6.8 |

## 2.8 Increased use of evidence and data

Agencies reported that the integrated health promotion plans were informed by an analysis of data from a range of sources, including international, national and state policy documents, state and local data sets and participation of consumers and community members. Initiatives such as the Care in Your Community Trials and the Community Indicators Project had resulted in access to higher quality data. Nevertheless, access to data (including via DHS) was still considered a key challenge in some locations. Two PCPs had developed a Data Working Group or similar, which were establishing a `warehouse' for shared data sets. Through planning together, participants felt that they were more rigorous in their health promotion work.

A document analysis of PCP CHPs indicated an increased use of evidence and data over time. There was an overall improvement in the use of data and evidence to establish integrated health promotion priorities. Both the quality and breadth of information used had increased. Sources such as Victorian Burden of Disease Study (2006), regional profiles from Australian Bureau of Statistics, Victorian Population Health Survey (2005) and municipal health plans were consistently used.

Other sources of data commonly used were the Ambulatory Care Sensitive Conditions Study (2005), Regional Health Profiles-Plexus Report (2005) Victorian Department of Sustainability website and local area studies providing information on such issues as Aboriginal health status and food security. There was inconsistent recording of evidence used to identify appropriate interventions in plans, however this does not indicate that evidence based interventions were not used.

## 2.9    PCP facilitation role essential to IHP

The evaluation found that overall the PCP partnership approach was considered essential to facilitating IHP.  It enabled the development and implementation of planning structures and processes which in turn led to a focussed health promotion effort to achieve greater impact. Whilst some member agencies acknowledged that they would have done some of this anyway, others commented that the role was critical in providing leadership and enabling a shared approach and a focus on agreed priorities.

The essential role of the PCP to IHP was supported by an analysis of questionnaire data. Success in IHP was seen to have increased as a result of the IHP strategy with an average statewide rating for this item of 6.7 out of 10.  Likewise, the PCP IHP approach was seen to have resulted in a clear and shared focus on agreed priorities, with an average statewide rating for this item of 7.1 out of 10.

The essential nature of the PCP IHP role was further evidenced by questionnaire results indicating that there have been clear improvements in health promotion collaboration and achievement of over the past three years – the average statewide rating for this item was 7.6 out of 10.

The three measures – success in IHP had increased as a result of the PCP IHP approach; collaboration and integration of PCP health promotion had improved over the past three years; and, the PCP IHP approach had resulted in a clear and shared focus on agreed priorities – provide clear evidence that the PCP IHP approach has been a key facilitator in the success of IHP.

**Figure 9: Facilitation of successful IHP**
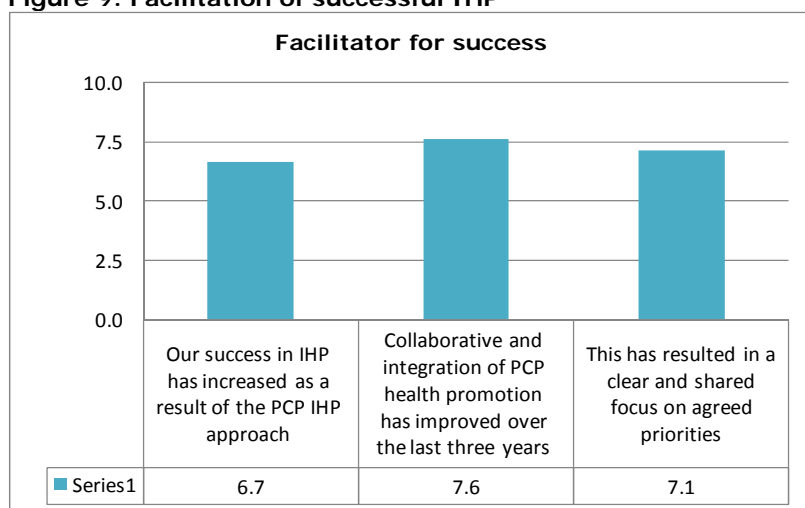


These findings are consistent with those of the Auditor General (2007, p34) who found evidence of regular communication and cooperation between local agencies.  The extent to which local agencies worked together varied, from the regular communication of information and the coordination of specific projects, to the more widespread integration of plans to promote health.  In each area audited, the PCP played an important role in bringing different organisations together.  Several PCPs had identified areas of overlap and duplication, and were working with member organisations to streamline and coordinate their efforts.

## 2.10  Case study: Together we do better

The case study illustrates how a PCP enabled a coordinated approach to integrated health promotion planning and has engaged agencies in the development of a partnership framework which was expected to support capacity for health promotion growth and activity in the area over the next three years.  Member agencies acknowledged that the investment in planning, which has been intensive at this time, will reduce the planning workload for member agencies in future.

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*Together we do better - integrated planning in practice*

The Campaspe PCP has designed and implemented a new integrated health promotion structure to further enhance integrated planning.  The PCP has used the tactic of invigorating planning structures, processes and tools, to result in multiple benefits for member agencies and the community.

*Planning structures*
Planning structures include an umbrella leadership group, with the mandate to provide strategic direction, monitor progress and ensure health promotion planning is linked to other key initiatives occurring in the region such as the Municipal Public Health Planning.  The leadership group plays a key role in ensuring the direct link and overlay with agency specific health promotion plans (e.g.  regional hospital, Sports Assembly).  The leadership group is supported on the ground by working groups for each of the agreed key health promotion priority areas.

*Planning processes*
The planning cycle is comprised of a combination of regular meetings, local planning workshops, and three general health promotion forums each year.  Together, these planning processes include the opportunity for reflection, the inclusion of new evidence and data and the consideration of the most effective approaches.  The processes provide a sequential and systematic approach with links between each component.  The planning process culminates in a series of key priorities, supported by member agencies, which are documented in the catchment wide integrated health promotion three-year plan.  Monitoring of implementation and reporting of the activities being undertaken in relation to the priorities listed in the three year plan, enable the plan to remain a 'living document'.

*Planning tools*
A range of planning tools are used to support planning structures and processes.  A priority setting protocol, or decision making matrix, is used during planning meetings to determine the key catchment wide priorities that ensure a shared commitment. Simple tools, such as planning flowcharts, checklists, meeting minutes, documented workshop reports, as well as communication bulletins, ensure a continual approach to keeping people abreast of the information used to inform planning.  At times, the use of an external consultant to analyse and summarise planning workshops and evidence based information has provided the group with expert advice and an independent review of partnership activities. This range of activities ensures good participation and communication in relation to planning processes and data.

*Benefits*
The strong leadership from the PCP and investment in integrated planning mechanisms, has resulted in positive relationships and an increase in the number of PCP member agencies.  In turn, this has resulted in an increased profile for health promotion and member agencies have noted a culture shift from agency-focused to catchment-focused health promotion, for example through partnership facilitated inter-agency submissions.  The approach has buoyed management and practitioner motivation.  It has supported effective implementation through more robust and consistent planning approaches and has reduced duplication of effort.  The approach has been a catalyst for attracting and leveraging resources as effective organisational partnerships have succeeded in attracting new financial resources and enabling economies of scale.

The strategy of investing in planning structures, processes and tools has had a net effect similar to compound interest – invest now and reap the returns over the coming years.  The PCP integrated health promotion approach has been the key driver for informed, coordinated, well financed and successful health promotion in the catchment.  As member agencies say: 'PCP provides the essential framework and structure for inter-agency integrated health promotion planning and delivery.  It has made a significant difference to our organisation and local area and we would not have programs and structures in place today without PCP IHP.' (Campaspe focus group)

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# 3 Organisational capacity for health promotion has increased

Capacity building is defined by Hawe et al., (2000) as the development of sustainable skills, organisational structures, resources and commitment to health improvement in health and other sectors. Key dimensions for capacity building change actions are identified as organisational development, workforce development, resource allocation, partnerships and leadership. The ability to build capacity and implement programs is central to PCP IHP program logic.

There was significant evidence to suggest that organisational capacity for health promotion has increased as a result of the IHP PCP approach. The evaluation identified multiple instances where a PCP IHP initiative has resulted in improved capacity through heightened health promotion awareness and skill development, and an increased focus on monitoring and evaluation of health promotion initiatives.

## 3.1 Leadership, awareness and sustainability

Agencies reported that PCPs had a key role in leading and motivating participation in IHP and that this resulted in an increased awareness about health promotion within organisations. Analysis of questionnaire results provided a statewide average rating of 7.4 out of 10, for the PCP role in leading and motivating participation. This indicates the perceived significance of this role.

Qualitative evidence, described by participants, included the shift to a more integrated and strategic approach to health promotion both within the PCP and in member agencies. For agencies this meant the development of partnership skills and a sustainable structure which provided a firm platform for health promotion work. There were regular timetables and structures for health promotion meetings which encouraged agency participation from senior management to practitioner level. In most PCPs there was a clear process for identifying and establishing projects as well as ensuring evaluation was built in to all health promotion work.
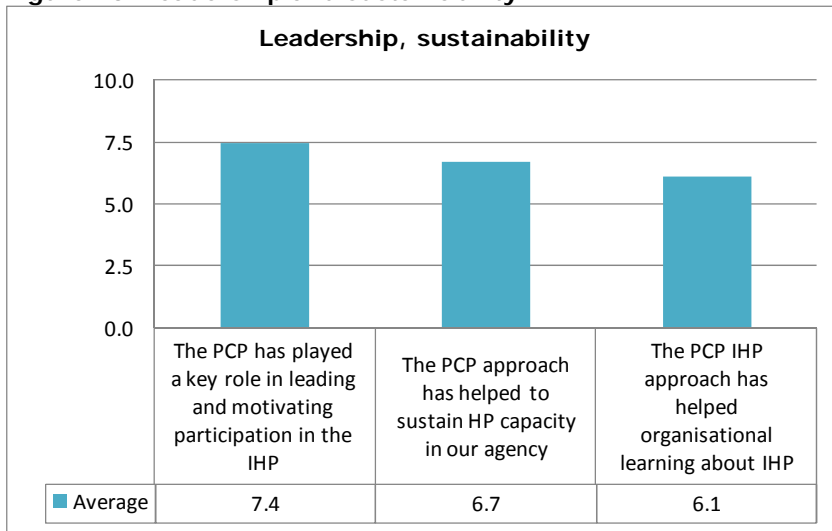
When asked about the impact if this leadership was not available, member agencies commented that networking might continue but the 'glue' needed for sustainable partnership work would be lost. They perceived the PCP leadership role as being continually building capacity to respond to health priorities in the catchment. In one PCP practical examples of this were the facilitation of a Nutrition Network, supported through PCP coordination, material and financial support, resource development and student placements.

Agencies reported ways in which the PCP IHP approach had enabled health promotion capacity to be built and sustained. The coordination of effort (e.g. planning, strategy development, submissions) across multiple agencies, through the PCP IHP processes and structures, was seen as a sustaining mechanism and one which would be beyond individual agencies to undertake. At an organisational level, capacity was sustained through continuing senior leadership representation at executive level of the PCP and agency policies and procedures reflecting integrated health promotion, the inclusion of health promotion in staff position descriptions, senior leadership and staff meeting agendas, policy documents and training and orientation programs within member agencies.

The partnership model with shared leadership, not dependent on the staff of a single organisation, was considered sustainable and resilient. For example, the way decisions were made about funding distribution, lead agencies for projects, and resources sharing between agencies were considered as transparent and sustainable partnership processes.

Analysis of questionnaire data provided evidence that the PCP IHP approach was seen to have some influence in terms of sustaining IHP capacity within agencies (Figure 10). A rating of 7.4 out of 10 for the PCP leadership role, 6.7 out of 10 for the PCP approach in supporting agency HP capacity and 6.1 out of 10 for organisational learning, suggest that the PCP approach has had a positive influence on capacity building. However, the ability to sustain capacity was attributed not only to the PCP but also to the leadership and decision making within an individual agency, which in turn was influenced by departmental guidelines and funding policies.

**Figure 10: Leadership and sustainability**



| | The PCP has played a key role in leading and motivating participation in the IHP | The PCP approach has helped to sustain HP capacity in our agency | The PCP IHP approach has helped organisational learning about IHP |
|---|---|---|---|
| ■ Average | 7.4 | 6.7 | 6.1 |

## 3.2 Increased profile at a senior level

Managers, senior staff and practitioners typically reported that health promotion had an increased profile within their organisations as a result of PCP IHP. This health promotion 'reach' stretched from awareness of the importance of health promotion at a organisational governance level by Board members - for example through regular health promotion reports and presentations at Board meetings – through senior and middle managers to the individual practitioner level.
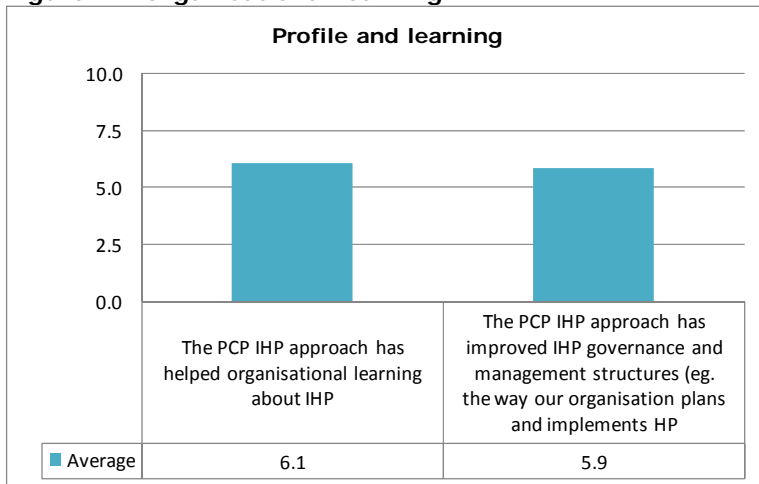
In terms of member agencies' capacity for IHP, the PCP approach was seen to have raised the profile of health promotion so that more managers and senior leaders were interested in becoming involved in health promotion issues. Agencies reported that more CEOs had an awareness of PCP IHP and training, so there was more senior level support for health promotion. Further evidence that the PCP IHP approach has been successful at building awareness at a senior level was the embedding of health promotion in agency strategic plans – reflecting support from both the CEO and the Board.

> 'The [PCP] provides leadership and legitimacy for all agencies to have a role in health promotion, and has enabled a cohesive approach to planning across the catchment.' (Focus group participant)

Increases in the amount of health promotion funds flowing through partnerships and the requirements to have submissions supported by partner agencies have also influenced senior management interest in IHP. Some agencies reported that they had developed or promoted health promotion management positions. For example, a District Health Service now has a health promotion program manager, where this was only a team leader role in the past. One local government described the building of organisational capacity from a situation where there was little understanding of their role in health promotion, to a situation where there was a committed workforce (3 EFT) and health promotion leadership within the organisation.

The PCP IHP approach has contributed marginally to improved governance and management structures for the planning and delivery of health promotion at an individual agency level. Analysis of questionnaire data indicated that the statewide rating for this aspect of PCP IHP had a lower rating than most other items, at 5.9 out of 10 (Figure 11). The PCP IHP approach was seen to have some influence on organisational learning, and this was reflected in comments in relation to workforce development.

**Figure 11: Organisational learning**



| | The PCP IHP approach has helped organisational learning about IHP | The PCP IHP approach has improved IHP governance and management structures (eg. the way our organisation plans and implements HP |
|---|---|---|
| ■ Average | 6.1 | 5.9 |

## 3.3 Workforce development

Agencies reported that PCPs had played a key role in workforce development, through increased access to health promotion training and skills development. Numerous respondents had access to PCP facilitated, organised or subsidised health promotion training courses, such the five-day Short Course in Health Promotion, Certificate IV Workplace Assessor training, Mental Health Promotion or Evaluation Capacity Building. Participants felt that workforce skills and therefore organisational capacity had developed through this training. Staff who would otherwise have been excluded had access to training as a result of the financial subsidy. Agencies tended to report that health promotion training opportunities were available to staff locally, whereas in the past people had to travel to attend them. This enabled more staff from a broader range of agencies to participate. Because training was inclusive of a broad range of staff, not just health promotion workers, a greater understanding of health promotion across the workforce was facilitated. Overall, the support of the PCP in training and development was seen to have made training more accessible to a larger number of staff.
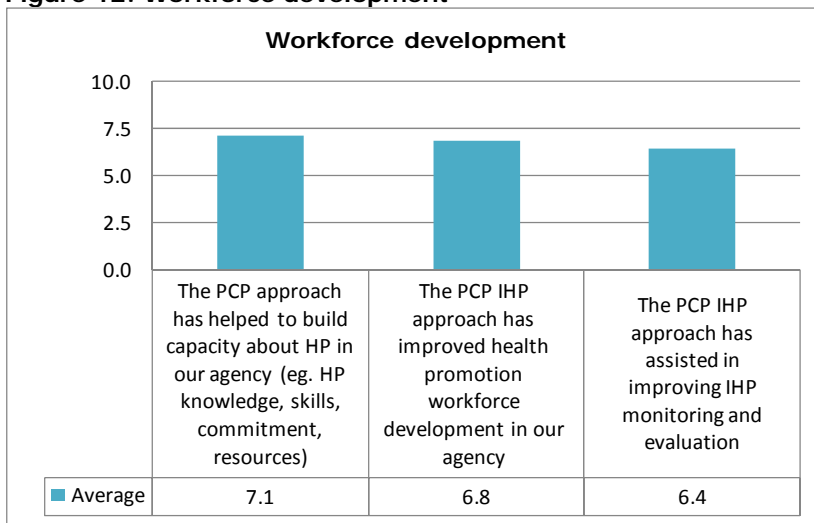
The PCP approach assisted organisational development and learning in other ways. Examples of this were the regular communications (meetings, emails and newsletters) provided through the PCP that connect agencies with up to date information, forums, workshops and training opportunities. This was of particular benefit to smaller agencies which do not receive this information from other sources. Linking non-health promotion staff with health promotion staff has enabled peer support across agencies.

This qualitative information was supported by an analysis of questionnaire results with a statewide average rating for the PCP IHP role in organisational capacity building of 7.1 out of 10, and for health promotion workforce development of 6.8 out of 10, indicating an important influence of the PCP IHP strategy on workforce development.

Member agencies commented that evaluation was an area where the PCP member agencies had improved skills and that there was now recognition for spending time in planning for evaluation at the beginning of projects. This had resulted in better data collection and measurement of outcomes. Some agencies reported that evaluation was being built into each project proposal. In one PCP, an informal system of peer review had commenced which would support the standard of evaluation for each project, and a mentoring model has been planned in order to support individuals in development of evaluation and other skills.

Member agencies also commented that evaluation was an area that was evolving, and still required further strengthening and ongoing support. This was supported by an analysis of questionnaire results with a statewide average rating for improving monitoring and evaluation of 6.4 out of 10, thus suggesting further opportunities in this area.

**Figure 12: Workforce development**



| | The PCP approach has helped to build capacity about HP in our agency (eg. HP knowledge, skills, commitment, resources) | The PCP IHP approach has improved health promotion workforce development in our agency | The PCP IHP approach has assisted in improving IHP monitoring and evaluation |
|---|---|---|---|
| Average | 7.1 | 6.8 | 6.4 |

### 3.4 Agency capacity to implement health promotion as everyday practice

Analysis of evaluation data indicates that the capacity of individual agencies to implement health promotion has increased as a result of PCP IHP strategies. For many agencies this has meant embedding health promotion into everyday practice.

> *'Prior to the PCP IHP strategy, health promotion was not a focus of our organisation. After being involved in the IHP we now have an interest in mental health promotion and have a better understanding of what this entails.'* (Questionnaire respondent)

An example of this was a Planned Activity Group where there was a focus on health and wellness throughout their program (e.g promotion of fruit and vegetables, cognitive and physical strength training, 'no falls' program). This was influenced as a result of increased access to training through the PCP and investment in personnel being involved in the PCP network.

Increasingly, health promotion knowledge and skills are requirements for practitioner roles and these are embedded into position descriptions and professional development. In one PCP, the inclusion of health promotion in everyday practice was supported by the requirement for grade 1 physiotherapists involved in the local network to complete a health promotion project as part of their training. This agency had also incorporated health promotion into agency staff induction and orientation programs. The 'No Bull' training provided to a range of staff and the evaluation project which has increased staff understanding and skill in building evaluation into projects were also examples of the way in which health promotion was embedded into practitioner roles.

Links with universities and statewide organisations for research projects, facilitated through PCPs, were perceived as strengthen the health promotion skills of practitioners. A number of smaller agencies represented indicated that without the PCP they would not have the capacity to run HP projects or programs but through the PCP they had access to evidence, data and staff who were able to support health promotion activity. These included neighbourhood houses, neighbourhood renewal programs, adult learning centres, family welfare services, Aboriginal health services and CALD agencies.

> *'We have been partners with other agencies in health promotion which would not have been possible in any other way as we are not funded for health promotion. This has increased our capacity to provide health promotion in our community' (Questionnaire respondent).*

## 3.5    Case study: Capacity building

The case study illustrates how a PCP has enabled capacity building across multiple agencies over a sustained period with a focus on a priority health area. The project focussed on capacity building within member agencies and seniors in the community.

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**Building capacity in falls prevention – Inner South East**

Falls prevention has been a priority for ISEPICH since the PCP strategy first began. A Falls Prevention project through the Commonwealth "Foothold on Safety" program had been conducted in the area, and agencies were interested in sustaining this work.

ISEPICH allocated $10,000 from Integrated Health Promotion funding in 2002 for a project to develop sustainability in falls prevention, and a project worker was employed through Caulfield Community Health Service. During 2002-03 the project worker facilitated the development of a sustainability framework, a Community Falls Prevention Network and a Strength Training Network. Ongoing peer education and workforce development strategies were also established.

Falls prevention work in ISEPICH continued over the following years. Outcomes included a growth in the number of strength training programs and the development of strength training information in several community languages. In 2005-06, ISEPICH and Kingston Bayside PCP jointly made a successful submission for funding from the Aged Care Branch, Department of Human Services, for the "No Falls" project for 2006-09. Bentleigh Bayside Community Health Service is the fund holder for this project.

The "No Falls" project has enabled ISEPICH to build on its work in falls prevention, and extend the initiatives across the two PCPs. The peer education program has been extended to include 14 peer educators, who between them speak six languages in addition to English. Over 800 senior citizens have attended peer education sessions. Fifty five workers attended a workforce training session on falls prevention in 2007, over forty attended a second session August 2008, and a Strength Training breakfast was held in Kingston Bayside. In addition the project has reached many community members through forums and other events.

Links have been formed with Seniors Registers in the cities of Glen Eira and Port Phillip. The Falls Prevention Community Network is also disseminating information about a local project to train seniors in safe tram travel, and forming links with walking groups and other related activities.

While the project funding has enabled expansion of activities, sustainability has been a key consideration throughout. The two PCPs may not be able to sustain all activities at the same level when funding ceases, but are working to ensure sustainability, particularly through ensuring falls prevention is built into PCP health promotion plans.

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# 4 Economic and other benefits are evident

Member agencies reported multiple benefits as a result of the PCP IHP approach. These included both tangible benefits, such as financial resources and access to health promotion training, as well as intangible benefits such as access to information and an increasing profile for health promotion. Economic benefits were evident in many catchments as a result of the IHP PCP approach. Member agencies reported that the PCP IHP approach had provided a platform for joint funding submissions, assisted to attract additional financial resources for health promotion to catchments and achieved leverage through a consolidation of effort.

## 4.1 Platform for joint funding submissions and attracting resources

Evaluation data indicates that the PCP IHP approach has facilitated joint submissions between agencies and a move away from competitive approaches towards collaboration for health promotion. For example, participants indicated that agencies were more likely to consider potential project funding together, and as a group, decide which agencies would be best placed to undertake the proposed project. Further, projects developed in this way were felt to provide better linkages and more effective use of resources. Several projects, including A 'Go For Your Life' physical activity project involving the Division of General Practice as well as other member agencies were cited as evidence of this.

In relation to coordinated submissions there was the ability between member agencies to collate local data and information. An example of this was a submission for an Alcohol and Drugs project, with the local government agency collecting demographic data and the community health service providing health related data. In this instance, the organisations had effectively collaborated and been able to apply their own expertise and skills to benefit the process.

One PCP reported that as a result of coordinated funding submissions there had been a significant increase in the amount of funding to the area, with an additional $1.17 million, and it was intended that this continue to grow.

> *'We know what's coming up - we meet and discuss the level of interest and capacity, plan approaches together and partner in submissions.'* (Focus group participant)

In another PCP, funding included Active Participation funding of $185,000 and Travel Smart funding of $103,000. Both projects, led by the local government, were developed through the PCP IHP framework. Other examples of successful joint submissions included funding for development of a community kitchen, funding for various physical activity groups, funding for community health workers to undertake Certificate 3 in fitness to facilitate group exercise classes.

## 4.2 Improved resource efficiency

Agencies reported that PCP IHP had impacted on resource identification and allocation in two key ways. Firstly, it was a platform to inform the distribution of selective DHS funding – for example the distribution of drought funding (2006); and secondly the PCP could identify new potential financial resources. Both of these roles were considered as important in terms of effective and efficient distribution of funds to benefit the community.

Some participants reported that PCP IHP has had played a role in 'scouting for funding opportunities' and bringing them to the attention of member agencies. Successful funding submissions then resulted in additional resources. The agreed and consistent process of consulting with members, identifying leaders and other stakeholders and providing input to submissions was considered to have made the process more efficient than it was in the past.

*'Before the PCP strategy agencies were fighting with each other for health promotion funds and now the PCP provides a culture and model of working together.' (Focus group respondent)*

In addition, the PCP IHP approach was considered as a protective strategy in terms of protecting agency health promotion resources from dilution due to competing agency priorities.

Agencies reported that the PCP IHP approach had a positive impact on the efficient use of resources. Analysis of questionnaire results provided a statewide average rating indicated that the PCP approach had reduced inefficiencies and duplication between agencies in relation to IHP to some degree, with a statewide average rating of 6.5 out of 10. Likewise, the PCP approach assisted in the efficient use of resources with a statewide average rating of 6.8 out of 10 (Figure 13). The PCP IHP approach was reported as having improved access to, and allocation of both financial and other IHP resources. Together, this cluster of measures provides evidence that the PCP IHP approach has had a positive impact in terms of the efficiency of IHP resource allocation and use.

**Figure 13: Resource allocation and efficiency**



| | The PCP IHP approach has improved access to, and allocation of, IHP resources (financial and other) | The PCP approach has assisted in the efficient use of resources | The PCP approach has reduced inefficiencies and duplication between agencies in relation to IHP |
|---|---|---|---|
| ■ Average | 7.0 | 6.8 | 6.5 |
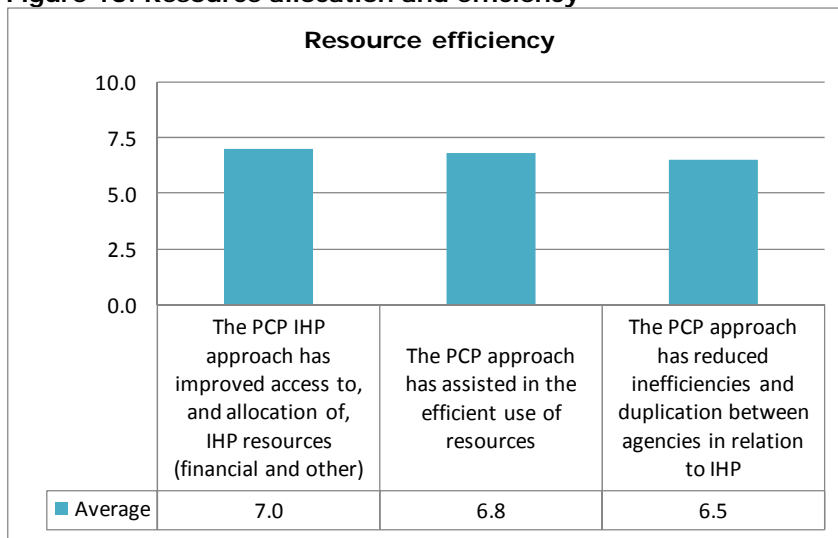
## 4.3    Leveraging from strong partnership approaches

Evaluation data indicated that the PCP IHP approach has been an effective way to leverage resources. For example, as noted above, the environment of mutual responsibility and consolidated effort has reduced duplication and contributed towards efficiencies and greater outcomes from finite resources. The approach enables individual agencies to leverage the collective knowledge, skills and to some extent, resources, of the partnership. For example, for a rural sporting association, the PCP platform connected them with health promotion financial resources and partners to enable plans to be implemented across communities. Working through the PCP was considered a cost efficient platform to achieve outcomes, and provided access to specialists in physical activity for member agencies.

For others, the PCP IHP approach provided the opportunity to leverage on the relationships with other agencies.
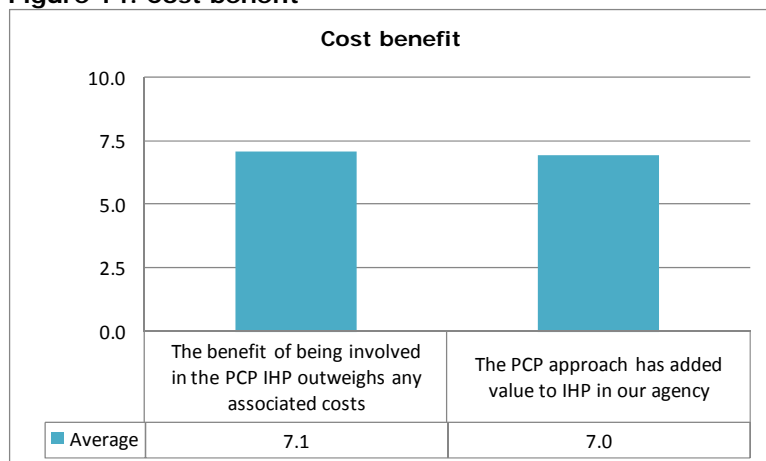
*'We are a regional Youth Mental Health service and we use the Youth Platforms of PCP where they exist as our Advisory group. In [catchment] they have combined the Youth Platform meeting and the Interagency Youth Meetings into one meeting which for a small regional service like mine means that one presentation at this meeting gives us access to all our Gate keeper services.'* (Questionnaire respondent)

## 4.4    Value added

The benefits of being involved in the PCP IHP were considered to outweigh the cost for member agencies.  Analysis of questionnaire results for whether the benefit of PCP IHP involvement outweighed the costs, resulted in a statewide average rating of 7.1 out of 10, indicative of the perceived benefit (Figure 14).  Agencies tended to report that the main cost associated with PCP IHP was the time invested in attending meetings and forums.  Whilst the minority of agencies reported that they were not always certain that their investment of time was beneficial – particularly once they 'got to know everyone,' the majority of agencies considered that these communication and decision making forums provided a good return on the investment of time.

Likewise, the PCP approach was considered to have added value to IHP for member agencies. Analysis of questionnaire results indicated a statewide average rating of 7.0 out of 10 for this item (Figure 14).  Whilst a minority of agencies were ambivalent about the value added, the qualitative and quantitative data indicated that the majority of agencies believed that the PCP approach had added value to IHP in their agency.

**Figure 14: Cost benefit**



| | Cost benefit | |
|---|---|---|
| | The benefit of being involved in the PCP IHP outweighs any associated costs | The PCP approach has added value to IHP in our agency |
| ■ Average | 7.1 | 7.0 |

## 4.5    Multiple benefits

Member agencies reported multiple benefits as summarised below (Table 1).  Benefits were not only immediate or short term (e.g. additional funding resources), but were also considered to have a longer term legacy for future high quality health promotion practice.
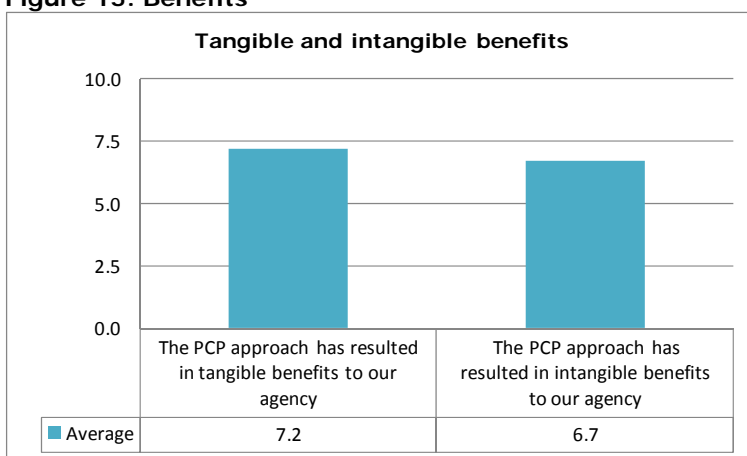
**Table 1: Benefits of PCP IHP for member agencies**

| Tangible benefits | Intangible benefits |
|---|---|
| Attracting additional financial resources to implement health promotion | Improved access to information, networks and knowledge |
| Shared funding submissions which are more successful than single agency ones | New ideas and innovations |
| Organisational capacity building and staff professional development - access to workforce development and training opportunities, including training targeted to local issues and agencies | Reduced competition and increased collaboration between agencies for health promotion resources |
| | Relationships and networks - a greater sense of trust and cooperation at both senior leadership and practitioner levels |
| Strategic outcomes, for example CALD framework, and focus on priority areas of health promotion | A much stronger focus on health promotion in agency strategic plans |
| Access to knowledge and evidence based information and resources | A broader spread of health promotion activity beyond the funded agencies |

| Tangible benefits | Intangible benefits |
| --- | --- |
| Access to health promotion training at a reasonable cost | Coordination and consistency of health promotion activities |
| Financial support for catering and guest speakers at health promotion events | Increased confidence amongst workforce in understanding and participating in integrated health promotion – understanding roles and having a shared language |
| Shared costs, for example access to venues such as those owned by Council, can be a huge saving for other member agencies | |
| Improved service links and connections between agencies which facilitate access to a broader range of supports and services for the community. | Exposure to experience in health promotion planning and evaluation |
| | Peer support from other members of the PCP network |
| Higher profile of HP in agencies and communities | An increased knowledge of the benefits of partnerships |
| Ability to provide more programs by sharing resources and working together | Integrating health promotion thinking and action into the agenda of agencies not traditionally working in that field |
| Effective use of time, travel and associated costs when working with multiple agencies | Better understanding of what non-traditional health agencies can contribute to health promotion |
| Access to high quality data, networking and information sharing. | For people who are new to their health promotion roles the PCP provides an instant network to access, facilitating orientation to the local service system and health promotion |
| Having the PCP staff provide a coordination role and a centralised point of information and reference | |
| Regular newsletters and updates | Support for submissions and implementation of projects |
| Health promotion embedded in position descriptions | Advocacy and input to agency plans, for example Community Mental Health Plan |
| Inclusion of mental health into mainstream health promotion | Health promotion principles are understood by more than just health promotion workers |

It is interesting to note that tangible benefits were reported as marginally higher than intangible benefits. Analysis of questionnaire results indicated a statewide average rating of 6.7 out of 10 for intangible benefits and 7.2 out of 10 for tangible benefits (Figure 15). This finding may indicate that agencies place a higher value on the receipt of tangible, rather than intangible, benefits. These two items indicate that member agencies both receive and value multiple benefits though their involvement in PCP IHP.

**Figure 15: Benefits**



| | The PCP approach has resulted in tangible benefits to our agency | The PCP approach has resulted in intangible benefits to our agency |
| --- | --- | --- |
| Average | 7.2 | 6.7 |

## 4.6　Case study: Financial benefits

This case study illustrates the financial benefits to communities where the PCP IHP approach has achieved positive partnership relationships, structures and processes that resulted in successful funding applications.

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**Goulburn Valley – Paying dividends**

The PCP IHP approach has provided an avenue for bringing significant resources into the local area targeting health promotion activity.  An average of $400,000 per year over the past five years has come through the PCP for specific health promotion projects.  Some examples are:

➜ Drought recovery projects: $100,000 per annum over two years
➜ Refugee service integration GP engagement: $25,000
➜ ICT project which provided efficient links for agencies to internet: $193,000
➜ Falls prevention project: $75,000 per annum for two years
➜ Diabetes Prevention 'Go For Your Life' project: $350,000 per year for two years
➜ GP small grants: $20,000
➜ Gamblers help integrated health promotion work: $10,000
➜ Well for life project: $25,000

*Structure*
Each project has reporting and accountability to the members through working groups and steering committees and to the PCP executive.  Funds come to the PCP and are either transferred to the designated lead agency or used to fund project workers within the PCP staff team.  The PCP has moved to support and empower member agencies to undertake project leadership and use their existing agency staff or employ new workers to implement projects.

*'Building relationships for solid partnership activities is a marathon, not a sprint.  It takes time, champions, commitment and perseverance.  If you want to truly work within a partnership model you have to take the extra steps and resist the temptation to 'just do it'* (Focus group participant)

*Process*
Goulburn Valley has built relationships between agencies and people within them, including CEOs, senior leaders and practitioners/project workers.  This provides the foundation of a solid partnership on which the process for developing funding submissions is based.  The PCP having identified needs, gaps and priorities for health promotion through planning is able to bring agency leaders with decision making capacity around the table to discuss possible funding submissions.  Members decide on which agency is in the best position to lead the project based on the service type, staffing, location and current activity.  They agree not to compete for the funds but rather to write letters of support and offer practical support where appropriate.

*'It is important when making decisions about funding submissions and lead agencies that the right people are at the table to start with, people with the ability to make those types of decisions on behalf of the agency'* (Focus group participant)

The writing of the submission is a shared process, where various staff contribute, based on their skills and access to information.

*'We were able to develop a submission for a Binge drinking project within one week.  The PCP executive officer with skills in submission writing developed the outline, the council worker provided the demographic data and collated the letters of support and the community health service developed the model.'* (Focus group participant)

*Benefits*
Financial resources are channelled efficiently through the most appropriate agencies, into communities to address priority health issues in that community.  The process of developing submissions enables commitment and support of partners to be established at the outset of each project.  Member agencies have information about projects and competition does not become a barrier.  Services are more likely to be complementary rather than duplicated and there is interagency accountability built in to the ongoing management of projects.  The staff in member agencies also have opportunities to develop project management skills and extra resources come into agencies to assist in addressing gaps.

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# 5 PCP IHP contributes to healthier communities

The scope of the evaluation does not include evaluation of individual health promotion initiatives, however the case studies and commentary in this section provide information and a sample of how local health promotion initiatives have contributed to healthier communities.

A key theme through consultation with member agencies was that the PCP IHP approach had benefited the local community through an increased ability to implement health promotion activities. A more planned and coordinated approach built on a stronger evidence base, had resulted in health promotion initiatives being better targeted to addressing local health priorities. The multi-agency, cross sector focus on an agreed health promotion priority meant that the community benefited from a more coordinated approach.

Agencies reported that links between health promotion, early intervention in chronic disease programs and service coordination had improved resulting in a growing understanding of how the work of PCPs can benefit the community. One example of this was how links to disease management programs (e.g. diabetes, cardiac programs) had resulted in input to the walking and cycling strategy, healthy design and travel smart. At a general level, as well as a project specific level, the PCP IHP strategy was clearly designed to support healthier communities.

## 5.1 Targeted projects and programs to support communities

PCPs have supported many health promotion initiatives and projects designed to improve the health of the community by addressing an agreed priority area. One PCP explained that the partnership between member agencies had allowed them to be strategic in how they individually used their influence to support the debate over a particular health issue in their catchment.

A more targeted evidence based approach had helped a PCP where there existed a mature partnership to analyse local burden of disease data and then focus on developing initiatives which would assist in long-term prevention strategies. The approach resulted in a stronger focus on 'start of life' issues for the catchment, including development of a new early language program.

Throughout the evaluation, member agencies cited many examples of health promotion projects that were being implemented as a result of PCP IHP or through the support of the PCP partnerships. In one region, a collaboration of community health services working with two local PCPs provided falls prevention awareness training. As a result of the partnerships, this community based training program was provided across a range of municipalities to many members of the community, and was considered successful in reaching non-English speaking consumers. Another project called 'New Horizons', was designed to provide support to carers when their care recipient moved into residential care. Through the PCP IHP approach, it had been possible to develop the critical mass for a central intake process across several local government areas.

Multiple IHP projects were identified by agencies as examples of successful PCP IHP initiatives. Amongst others, these included:

- Active participation project
- Travel smart
- Kids Go for your Life
- Move and groove
- 10,000 Steps program
- Active Communities Partnership
- Lifeball
- Mental Health Week Art Exhibition "Beautiful Hands, Brilliant Minds"

- Making Two Worlds Work
- Poolwalking Project
- Mental Health First Aid
- Sustainable Farming Families
- Pitstop
- Active Script
- Welfare to Work
- Stepping Out
- Father and Son Night
- Diabetes Working Group
- Youth Bus Initiative
- Rooming House study
- Seniors Go for your Life
- Strength and Balance training
- Equity Project
- Family Violence Action Plan
- KickStart
- Physical Activity Network
- Food Security research
- Mental health well-being project
- Pedometer challenge
- Farm Gate model
- Consumer participation project
- Advocacy workshop for parents of children with disabilities
- Food Security project.

## 5.2    Case study: A coordinated approach

The case study below provides an example of a PCP which used a coordinated approach to consider new approaches to encouraging increased levels of physical activity on a catchment-wide basis.  The approach in this area reportedly improved the focus of work so that it was more targeted to the clients with the greatest need.

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**Active Broadmeadows**

The Go for Your Life (GFYL) – Active places project is a three year project (commenced in 2007), aiming to increase physical activity levels, reduce sedentary behaviour and increase active transport in a defined geographic area – the Broadmeadows Community Neighbourhood Renewal (BCNR) area.

The project combines a strategic health planning approach with community development, in which residents are key participants in the project.  Led by Dianella Community Health Service, the project partners include: Hume City Council, Broadmeadows Community Neighbourhood Renewal, Hume Moreland Primary Care Partnership, Homeground Services, Dallas Neighbourhood House, Broadmeadows Disability Service, Melbourne City Mission, Campmeadows Primary School and Preschool, and Meadowbank Primary School and Preschool.  The project draws on the health planning skills of the Hume Moreland Primary Care Partnership Health Promotion Implementation Group, to further build capacity of the project partners.

A mapping process (Active Places Physical Activity) documented current physical activity opportunities, facilities and infrastructure available; barriers and constraints to physical activity and the needs of the area.  Strategies devised from this initial research and the focus of work over the next twelve months include: the establishment of Tai Chi programs in partnership with Arthritis Victoria; establishment of local cycling groups with Bicycle Victoria; establishment of local cycling groups in partnership with Bicycle Victoria; identifying appropriate physical activity options for women's groups, multicultural groups and CALD communities; supporting the implementation of the Walking School Bus in the area and encouraging cycling to and from school in partnership with Bicycle Victoria; and integrating physical activity into after school and holiday programs, and programs targeting pre-school children and their families.

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## 5.3　Case study: A respectful and symbolic approach

Other projects were successful in assisting to create stronger links with parts of the community which may not traditionally have had strong links to the overall health system. The case study below illustrates how one PCP was able to support an initiative designed to have a lasting positive impact on the relationship with Aboriginal agencies.

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**Making Two Worlds Work**

As part of an overall equity project, the `Making Two Worlds Work' project involved the development of a practical and creative resource kit to support local health and community agencies to work effectively and respectfully with local Aboriginal clients and community. A community strengthening and development approach was used.

*Partnership/planning*
The Upper Hume PCP has focused on building the capacity of member organisations in developing policy and practice that result in equitable outcomes in its communities. It had objectives related to 'equity' built into all levels of the UHPCP Healthy Communities Plan to facilitate both agency-based equity initiatives and regional equity policies, practices and workforce training.

The `Making Two Worlds Work' project grew out this focus and an identified gap in level of engagement of member agencies with the Aboriginal community. A need was identified amongst various agencies in the region for cultural awareness training for staff to help them understand the culture of the local Aboriginal communities in order to provide more appropriate programs and services. In addition, agencies expressed a desire to have locally produced Aboriginal artwork and images they could display in their agencies, accessible information about local Aboriginal history and culture, protocols, key organisations and contacts, and resources to support their work with Aboriginal clients, families and community.

*Process*
The project was coordinated by Mungabareena Aboriginal Corporation and Women's Health Goulburn North East using Indigenous health promotion and community development principles. Art was used as a way to involve the Aboriginal community and acknowledge the essential role that storytelling, art and symbols play as culturally appropriate communication mechanisms. As a result there are six impressive paintings depicting aspects of health and wellbeing that form the foundation visual imagery for a resource kit.

The Aboriginal community was involved in all aspects of decision-making along the way. This included a number of 'community conversations' about health and wellbeing to inform the project and to provide feedback. The local Health Portfolio Network meetings, held monthly and attended by workers from Aboriginal organisations and generalist services, acted as a reference group. This meant that a diverse and fluid range of workers also contributed to the evolution of the resources. Well over 120 individual, workers and agencies – Aboriginal and non-Aboriginal – have been involved in the development of the artwork and resources.

`*I feel that involving the community in the art and the content of the posters gave them power and ownership there and then. They were the ones having a say, they really felt connected then.'* (Making Two Worlds Work participant)

The resource kit contains:
- A suite of six posters developed from the original paintings
- A 'Working with Aboriginal clients and community' audit tool for agency planning and review; A checklist for working with Aboriginal clients
- A Health Promotion Framework with an 'Aboriginal lens'
- A CD of over 100 graphic images based on the six paintings for agencies to use when designing written or visual information for Aboriginal clients and community
- A DVD that explains 'Indigenous Welcomes' and 'Acknowledging Country', and describes the importance of art for Aboriginal communities
- Signage for services to welcome Aboriginal and Torres Strait Islanders to their agency
- An Information Guide that includes local knowledge about culture and history, frequently asked questions, key Aboriginal organisations and contacts.

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Staff from Aboriginal organisations went on to gain training qualifications from the local TAFE to build capacity for conducting Aboriginal cultural awareness training.  The 'Making Two Worlds Work Resource Kit' was made available from Mungabareena and WHGNE, providing access to this content across a broader number and range of agencies and to workers who are unable to attend training programs.  The paintings are displayed in reception and waiting areas of local agencies, contributing to a welcoming environment for Aboriginal clients.

*Benefits*
The project and the artwork produced for the kit are a reminder of the important role of story-telling, art and symbols in culturally appropriate communication and local artists have their work displayed.

Increased level of skills within the local Aboriginal organisations to continue to work in partnership with generalist services.  Practical, locally relevant resources for generalist agencies to support ongoing organisational change are available.  There should be a significant increase in the visibility of symbols of welcome, and the use of the local artwork and images for designing written or visual information.  Ultimately, more Aboriginal people should be accessing their local health services.

*'We have evidence already, although it is early days, that this approach has made a difference to our community members accessing generalist health services'* (Making Two Worlds Work project worker)
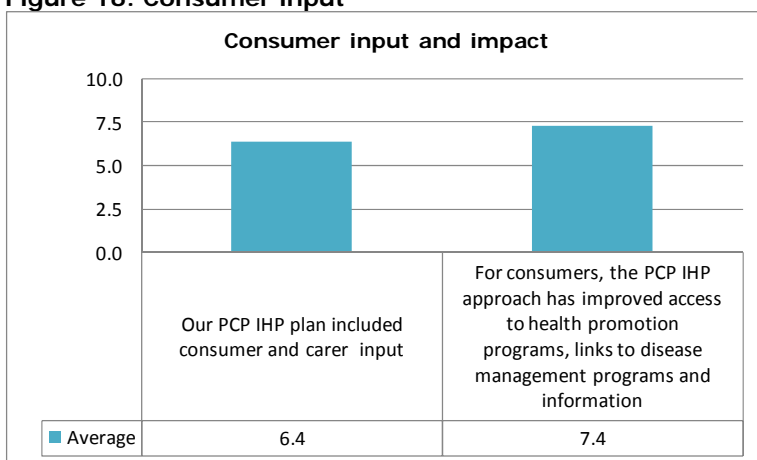
The next stage of the project is to build on these resources by supporting the development of a local Aboriginal Impact Guide for policy development and review.  The Upper Hume Primary Care Partnership members will work in a team to develop trial and implement this.

## 5.4   Consumer input and consultation

The PCP IHP Planning Frameworks have supported member agencies in ensuring that more strategies for involving consumers are developed and incorporated into planning.  Some PCPs have a process of community consultation and consumer input into community health plans (three out of the nine in the sample group) and also indicated ongoing consumer participation at various levels of the partnership.  While not all agencies reported they were successful in including consumer and carer input, those agencies that had been able to incorporate consumer input, felt that it had helped to improve access to health promotion programs.

Analysis of questionnaire results indicated a statewide average rating of 6.4 out of 10 for consumer and carer input to IHP plans (Figure 16).  There was a substantial level of agreement, rated at 7.4 out of 10 that the PCP IHP strategy had improved consumer access to health promotion programs and information.

**Figure 16: Consumer input**



**Consumer input and impact**

| | Our PCP IHP plan included consumer and carer  input | For consumers, the PCP IHP approach has improved access to health promotion programs, links to disease management programs and information |
|---|---|---|
| Average | 6.4 | 7.4 |

## 5.5    Case study: Community consultation

As illustrated by the case study below, the PCP IHP approach has supported agencies in developing new approaches to local consultation.

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**A Local Response to Welfare to Work**

In 2006, the Australian Government introduced legislative changes relating to the payment of disability support and parenting benefits (the "Welfare to Work" changes), including new activity requirements for people receiving these benefits, and changed activity requirements for mature aged job seekers and very long term unemployed people.  Community agencies were concerned about the impact these changes would have on vulnerable citizens, who faced increased obligations, reduced income and punitive measures to enforce compliance.

Member agencies of the Inner South East Partnership in Community and Health (ISEPICH), and the ISEPICH Community Advisory Group developed a local consultation and advocacy project to monitor the impact of the changes and develop a local response to them.  The project's focus is on the experiences of individuals affected, asking them to tell their own stories.  This approach presents its own challenges, including identifying Welfare to Work related Centrelink issues, and ensuring that isolated people know about the project.

To date, stories have been received from 21 individuals.  On the basis of this information, ISEPICH and member agencies have been able to raise community awareness and advocate to policy makers.  The project has been successful in three key areas: collecting stories, advocating with government and broader community through the local media and creating linkages between agency peak bodies and grassroots service delivery agencies.

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## 5.6    Case study: Building sustainable systems to support healthy communities

This case study illustrates the role of General practice in PCP IHP and shows the effect of sustained focus, learning from and building on results It describes the combination of multiple strategies at multiple levels, involving a range of key stakeholders and the community.

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**Building healthier communities-Wimmera on the move**

The partnership in Wimmera has established a sustainable system which continues to grow, aimed at increasing physical activity levels across the community.  It includes the use of the Active Script and referral pathways (moving towards electronic referral systems) by GPs, to Physical Activity Enablers based in a range of community agencies, who support clients in increasing their physical activity levels, and provide feedback to the GPs.  Expanding the range and number of physical activity options in the region is part of building the system.  The 'Active Script', 'Walking Wimmera' and physical activity training for staff in agencies were commenced in 2002.  The model has evolved to include a focus on nutrition and service coordination has been built in over time.  A self management approach is employed by the Enablers.

*Planning*
Increasing physical activity has been a priority of integrated health planning in Wimmera since 2001.  The goal `To increase active participation and opportunities for physical activity for everybody throughout the communities within the WPCP catchment' is articulated in the Wimmera PCP Well Being plan 2006-2009.  Agencies in the area, including health services, councils, community houses, community health, GPs continue to commit to this through their participation.

*Evidence based approach*
The most effective physical activity interventions are those that combine multiple strategies at multiple levels and involve a range of key stakeholders and the community.  It involves using capacity building strategies for developing leadership, building partnerships and facilitating cooperation.  Recommended interventions for physical activity include:
• Build public policy for physical activity: promote, develop and support public policy that facilitates and encourages physical activity.

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• Promote, develop, support and initiate actions for increased and equitable access to environments that support people to be active.
• Promote and support individuals, communities and organisations to encourage and influence social and cultural norms that support physical activity.
• Increase awareness and understanding of the benefits of participation in physical activity, develop skills to be active as part of daily life and support individuals, families and communities to overcome barriers to physical activity.
• Building the health sector's capacity for sustained and coordinated action by strengthening skills, competencies and infrastructure, including funding, workforce, leadership and organisational support.
(Garrad etal. 2004; Victorian Health Promotion Foundation 2005)

Data collection and evaluation have been built into the system since the commencement of the project and there is an ongoing quality improvement cycle in place.

*Process*
West Vic Division of General Practice took the lead role and funding has been provided through DHS GP small grants and the Wimmera PCP which has supported the implementation and growth of the Active Script component.  Partners have worked collaboratively to support further successful funding submissions to VicHealth which have enabled the development of strength training programs and walking programs for newly identified clients to be linked into.  Various agencies support the system through the provision of designated positions within their organisation which incorporate the 'Enabler' role into position descriptions.  Protocols and training are provided to the Enablers.  An online data base has been developed to support referrals www.sportslink.org.au/wimmera. This allows both Enablers and the public to seek local options to get active.

*Benefits*
A survey in December 2007 of clients who had been through the Active Script program in the two years prior showed that people had found the 'Enablers' very supportive and there had been significant lifestyle improvements in the areas of activity levels 35%, weight 48%, blood pressure 32%, cholesterol 19% and diet 55%.

By 2008 there were 82 GPs in the area referring to the Active Script program with 10 partner agencies involved and seven Enablers working across the agencies.  Local community groups had established numerous physical activity options which were listed on a public website and advertised throughout the communities.

# 6 Barriers and enablers

Analysis of information from focus groups, questionnaires and key informant interviews identified a range of enablers and barriers to the successful development and implementation of PCP IHP. Success factors and opportunities for continuous improvement were also identified.

## 6.1 Key enablers

Key enablers of successful PCP IHP identified by members have been incorporated into the discussion in earlier chapters of the report. Further examples are shown in Figure 17.

**Figure 17: Enablers**

| Category | Examples |
|---|---|
| Communication | • The leadership and professional skill of the PCP Executive/health promotion officer<br>• Effective communication at all levels across the PCP members and within agencies<br>• Consulting with agencies about "what they want to get out of the partnership"<br>• The ability of the PCP staff to act as a conduit from DHS by bringing back information, trends, big picture issues to agencies<br>• Having meeting times, content (relevance) and structures that suit all members |
| Roles and relationships | • Longer term mature relationships<br>• Clarity of roles and common purpose |
| IHP practice and culture | • Having skilled workers who are good at research, gathering and sharing information<br>• Providing a model for best practice health promotion<br>• Enthusiasm and interest in integrated health promotion<br>• The willingness to assist and support each other |
| Policy, planning and resources | • Policies, guidelines and funding requirements which require demonstrated partnership<br>• Simple and streamlined planning/reporting requirements- a plan which links to and is relevant to the needs of member agencies - The concept of 'one plan one report'<br>• Adequate resources |

## 6.2 Barriers

Although there was evidence of significant benefits as a result of the PCP IHP approach, a number of barriers to success were reported by member agencies. These included barriers related to workload, planning, workforce and communication issues (Figure 18). The examples shown reflect the views of individual agencies. The most common barrier reported was the lack of alignment of planning cycles and the number and complexity of health promotion related plans required to be completed by various funding bodies.

**Figure 18: Barriers**

| Category | Examples |
|---|---|
| Planning | • The lack of alignment in planning cycles between the PCP and local government<br>• Lack of clarity about the overlap between planning for PCP IHP and the Municipal Public Health Plan which is a legislated requirement for local government<br>• Complexity of planning and reporting requirements which detracts from other more productive activities<br>• Planning across multiple boundaries (LGAs, PCPS, Divisions of General Practice, sports assemblies, health services)<br>• The PCP is sometimes perceived as 'just another planning layer'<br>• Different community profiles and needs within different parts of the catchment |
| Workload | • Overload on agencies covering catchments across multiple PCPs<br>• Constant changes and demands on the PCP which made it difficult to respond to member agency needs<br>• Different and overlapping agency representation and networks within a catchment<br>• Lack of commitment or enough time to be involved from some agencies |
| Communication | • Lack of clarity about the role of the PCP and where and how the PCP can add value<br>• Lack of relevance when agency priorities are not represented at the PCP platform<br>• Tensions between DHS central office and regional office<br>• Ability to partner effectively with more clinically focussed services |
| Workforce | • Lack of availability of health promotion workers in rural areas<br>• Staff leaving and difficulties in recruitment to the area |

## 6.3 Member agency identified success factors

Similar to the enablers noted above, member agencies identified a number of key success factors which contributed to successful implementation of PCP IHP approaches. These included:

- The PCP acting as a resource, providing centralised information and advice, leadership and support for member agencies
- Recognising that stakeholders include PCP staff, member agency practitioners and senior management, as well as consumers as having a key role in PCP planning
- Attitudes of stakeholders – towards health promotion in general but also to other agencies and the PCP
- Congruence between identified local health promotion needs and that of funding bodies enabling resources to flow to priority areas
- Talking the same language and having a shared understanding of the determinants of health
- Ability of individual PCP staff, practitioners and senior managers to communicate about and advocate for integrated health promotion.

## 6.4 Continuous improvement opportunities

Although there was a high degree of satisfaction with the way in which PCP IHP had been implemented, member agencies felt there was capacity for ongoing improvement. Suggestions made during focus groups and on questionnaires have been grouped into the three categories of: improving quality; ensuring engagement, commitment and inclusion; and streamlining planning.

**Figure 19: Continuous improvement**

| Category | Examples |
|---|---|
| Improving quality | • A greater role for PCP staff to create a central online area for collection of evidence e.g. Community indicators and Plexus studies<br>• Focus on fewer strategies of higher quality and bring the relevant players to the table<br>• Build in evaluation and ensure that the outcomes from an IHP approach can be articulated<br>• Opportunities for member agencies to add to the health promotion evidence of what works and what doesn't through involvement in region/catchment-wide research<br>• Regular evaluation of the partnership, including reviewing the vision and identification of strategies for improvement<br>• Ongoing support from DHS for capacity building including workforce development |
| Ensuring engagement, commitment and inclusion | • Provide induction to the network to all new staff representatives and ascertain clearer understanding of the commitment of each agency to IHP and the PCP<br>• Orientation for new people coming into the network is ongoing –invest in the orientation to the network as well as their own local area due to staff turnover<br>• Improved engagement and commitment at senior leadership and practitioner levels<br>• Simplify the structure of the PCP as many agencies are over extended in their involvement<br>• Participation of all agencies in the development of plans<br>• Integrated Mental Health needs to be approached in a more coordinated way |
| Streamlining planning | • Further alignment of local government, community health, GP Division and PCP planning<br>• Reduction in the number of DHS Health Promotion priorities to be more aligned with State and National Health Priorities - while it is acknowledged that there are individual differences between agencies in the focus of their health promotion work, if the approach at a catchment level is too fragmented this works against the principle of coordinated effort<br>• Break down the silos between integrated chronic disease management, service coordination and health promotion working groups.<br>• More consistent approach between DHS central and regional health promotion officers<br>• Improved clarity and simplification of expectations from DHS, including fewer requirements for planning and reporting, and relevant timely feedback on plans.<br>• Reduce duplication of reporting (e.g. Community health service plans and PCP plans) - one plan instead of many<br>• Ensure that the work of the PCP remains at a strategic level, ie. supporting agencies to work collaboratively on issues that can not readily be addressed by individual agencies in isolation. The role of the PCP should not be to simply compile reports on the work agencies are currently undertaking. |

# 7     Conclusion

The evaluation found that the impact on member agencies of the PCP IHP strategy was, overall, positive and valued.  Based on the evidence gained throughout the evaluation, positive improvements in IHP capacity and quality since the introduction of the strategy are clearly evident.

Whilst there was variation between individual PCPs, with some member agencies reporting PCPs as more effective and valued than others, the PCP IHP strategy was, overall, perceived as a positive investment, with a successful track record in attracting resources and delivering economic benefits through better planning, coordination and collaboration.  Evaluation data indicates that PCP IHP has become increasingly effective over time as PCP leadership has resulted in network relationships that have broadened and matured resulting in increased capacity and sustainability over time.  The PCP IHP strategy has acted as a catalyst for capacity building and has resulted in a virtual wealth of IHP knowledge and skills and a clear increase in IHP quality.

As evidenced by the evaluation findings, there was increased recognition within member agencies that the IHP approach was credible and valued for the multiple benefits it generates for member agencies.

The evaluation found that:

- PCP IHP is a catalyst for capacity building in PCP member agencies
- PCP IHP generates multiple benefits and effective use of resources for PCP member agencies
- PCP IHP is valued by member agencies and is effective
- There is clear evidence of an increase of IHP effectiveness and quality since the introduction of the strategy.

**PCP IHP as a catalyst for capacity building**

A key finding of the evaluation was that successful partnerships are a catalyst for building health promotion capacity in organisations.  One way this has been achieved was through the development of skills, knowledge and learning within organisations.  Evaluation data indicated that the statewide PCP IHP approach has created a virtual knowledge bank in relation to the health of local communities and health promotion strategies.  This has been achieved through a range of strategies, including:

- Knowledge creation and HP information dissemination dispersion: PCP IHP has provided a mechanism for knowledge creation and dispersion.  This has resulted in a collective wealth of knowledge across all agencies.
- Span of participation: PCP IHP has increased the span of participation in health promotion.
- Involvement of small agencies: PCP IHP has enabled small agencies to tap into a knowledge and resource base, and access a range of tangible and intangible resources.
- Quality planning: PCP IHP has brought greater knowledge and expertise to the development of health promotion plans and interventions.
- Shared goals: PCP IHP has successfully leveraged the collective knowledge of agencies to develop and achieve shared health promotion goals.

**PCP IHP generates multiple benefits and efficient use of resources**

A key finding of the evaluation was that in areas where the partnerships were considered effective, there were clear benefits for member agencies and the efficient use of resources. These included both tangible and intangible benefits. Tangible benefits, such as access to training and attracting additional resources, were most valued by member agencies. Agencies reported improved access to, and efficient use of resources. The majority of member agencies perceived that their investment of time and effort generated positive outcomes and a reasonable return on their investment.

**PCP IHP is valued and effective**

The evaluation found that the PCP IHP strategy was valued by member agencies and had resulted in a perceived increase in effectiveness over time. As discussed in the body of the report and shown in Figure 20, member agencies reported a dramatic increase in the overall effectiveness of IHP before and after the PCP IHP strategy. Questionnaire quantitative data analysis indicated that the effectiveness of IHP had improved substantially (almost doubled) over time - from prior to the PCP IHP strategy to the current time. This was confirmed by qualitative data from focus groups.

**Figure 20: Overall effectiveness of IHP**
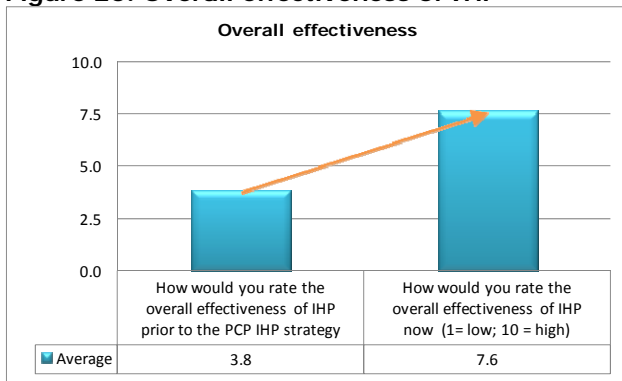


**Clear evidence of an increase in quality**

As discussed in the body of the report and shown in Figure 21, member agencies reported a dramatic increase in the overall quality of IHP before and after the PCP IHP strategy. Questionnaire quantitative data analysis indicated that the quality of IHP had improved substantially (almost doubled) over time - from prior to the PCP IHP strategy to the current time. This evaluation finding provides robust evidence of the success of the partnership approach to improved IHP and the impact of the PCP IHP strategy.

**Figure 21: Change in IHP quality**
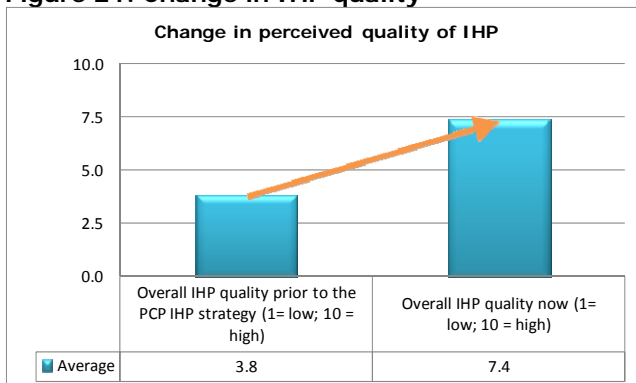
**Areas for improvement**

Whilst the majority of evaluation findings were positive, there were, nevertheless two key areas in which the results were less positive. The first of these was in relation to planning and the nexus between local government planning requirements, organisational or funding body planning requirements and IHP planning. Whilst respondents reported that planning processes had become less duplicitous and more streamlined over time, the planning was highlighted as a key area for improvement.

The second area in which results were less positive was the variability between individual PCPs. Whilst the majority of PCPs reflected positive evaluation findings, there were some areas in which this was not the case and where member agencies questioned the benefits. This tended to be where PCP leadership was perceived as less effective, where there had been multiple changes or where the culture and commitment of the partnership was not seen as conducive to maximising outcomes.

In addition to the specific issues identified above, the most common barriers described by member agencies were related to workload, planning, workforce and communication issues.

**Success factors for IHP**

Successful application of the IHP strategy through PCPs was influenced by numerous factors identified by member agencies. Broadly, enabling factors were identified as clarity about roles and relationships, positive attitudes by stakeholders about IHP and by member agencies towards the PCP and each other, stakeholders with a common purpose, effective leadership and skills demonstrated by the PCP, effective communication at all levels, and policy, planning process and resources supportive of IHP.

In conclusion, the analysis of impacts on agencies of the PCP IHP strategy suggests that over the eight years since the introduction of the PCP IHP strategy, the strategy has been a powerful and effective way of strengthening integrated health promotion.

The strategy has generated a range of outcomes at a systemic, catchment, local community, agency and logically, consumer level. Continued implementation of the strategy will continue to build the capacity of organisations to plan and deliver integrated health promotion to contribute to positive health outcomes for the community. The recommendations are designed to assist this process.

**Recommendations**

Based on the evaluation findings, a series of recommendations have been developed to inform ongoing implementation of the PCP IHP strategy. Described in Table 3, the recommendations address five key areas:

1. Engage key stakeholders
2. Streamline planning
3. Continue investment in workforce development
4. Strengthen evaluation and quality improvement
5. Focus on tangible benefits.

**Table 2: Recommendations**

| Area | | Recommendation | Rationale | Desired outcome |
|---|---|---|---|---|
| **1. Engage key stakeholders** | 1.1 | That DHS, PCPs and agencies engage community members in a planned way | Evaluation data indicated that a key area for improvement was the input by consumers and carers to the planning process. | An improved rating for the level of community input to IHP planning is evident |
| | 1.2 | That DHS, PCPs and agencies promote commitment to PCP IHP at the senior leadership level | Whilst evaluation data indicated that the profile of IHP had increased within member agencies, this was not clearly reflected in agency management structures. | Ongoing commitment to IHP at all levels within PCP member agencies |
| **2. Streamline planning** | 2.1 | That DHS continues to work towards more streamlined planning and reporting processes | Evaluation findings indicated that further alignment of local government, community health, GP Division planning and reporting cycles would be beneficial and increase efficiency. | Reduced duplication of reporting (e.g. local government, PCP, agencies) and further alignment of planning cycles |
| **3. Continue investment in workforce development** | 3.1 | That further investment in IHP workforce development is embraced by all parts of the sector | Evaluation results indicated the important influence of the PCP IHP strategy on workforce development. | Ongoing financial investment in workforce IHP skills development |
| | 3.2 | That agencies invest in IHP skills development for staff | Agencies reported that PCPs had played a key role in workforce development, through increased access to health promotion training and skills development. | IHP skills development strategies are documented in agency training plans |
| **4. Strengthen evaluation and quality improvement** | 4.1 | That the development and acquisition of evaluation skills continues to be promoted | Evaluation findings indicated that IHP evaluation was an area that was evolving and would benefit from further strengthening. | Evaluation of IHP initiatives, including impact evaluation is included for all IHP strategies |
| | 4.2 | That regular evaluation of the partnership is undertaken | Qualitative feedback highlighted the importance of regularly reviewing partnership performance and achievements to identify strategies for continued improvement. | Regular review of partnership outcomes and evidence of quality improvement activities |
| | 4.3 | That achievements, impacts and outcomes are collated and analysed | PCPs can reflect on the evaluation findings and practice evidence described in this report to inform their continuous improvement. | Agreed performance measures to enable monitoring of achievements |
| **5. Focus on tangible benefits** | 5.1 | That tangible benefits for member agencies are identified, measured and results disseminated | Evaluation data indicated the importance of both tangible and intangible benefits. Agencies relate PCP IHP success to the presence of tangible benefits for the community in return for their investment. | Member agencies can identify and report tangible benefits for their community in return for their investment in PCP IHP |

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# Appendix 1: Evaluation methodology

**Program logic**

The program logic for the PCP IHP Strategy describes the overall goals of the strategy as to:

> *'Enhance wellbeing and quality of life, reduce the prevalence and incidence of disease, reduce the burden of illness/disability, and reduce health inequalities between population subgroups.'*

Indicators for the strategy include a range of impact indicators and process indictors. This evaluation was related to the process indicators (Figure 22).

**Figure 22: PCP IHP Processes and indicators[1]**

PCPs develop comprehensive health promotion strategies as part of Integrated Service Plans, which address the health and wellbeing issues that are of common significance to consumers and the broader catchment population.
- Health promotion strategies are informed by data about the demographic and social characteristics and health and wellbeing of the population, participation of consumers, and carers and the broader catchment population, and national and state policy documents
- Health promotion program plans identify goals, objectives, target groups, the range of interventions, the roles and responsibilities of partner agencies, and indicators of progress for evaluation
- Health promotion program plans include strategies for building capacity for health promotion in PCP member agencies and throughout the wider catchment area.

Build capacity and implement integrated health promotion programs that address the health and wellbeing issues that are of common significance to consumers and the broader catchment population.
- Capacity for health promotion is built in PCP member agencies and the wider PCP catchment areas (including resource allocation, workforce development, organisational development, leadership, partnerships, involvement of consumers, development of management and governance structures, and monitoring and evaluation):
- PCPs implement health promotion programs that involve cooperative and coordinated effort between PCP member agencies, between PCPs, across programs and sectors and involve a variety of provider, consumer and community groups including local and statewide organisations;
- Access to (selectively targeted) health promotion programs is facilitated by streamlined needs identification, assessment and client information management processes;
- Health promotion strategies address the needs of consumers of disease management programs and are directly linked to these programs;
- Service users and broader populations are provided with health information and advice via new technologies such as the Internet.

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[1] DHS PCP IHP program logic documentation

**Sample group**

A purposive sample group of nine PCPs and their member agencies was constructed to reflect key variables:

- All DHS regions
- Metropolitan (inner, middle, outer urban), regional city and rural locations
- The seven health promotion priorities 2007–12
- Key stakeholder groups (e.g. GP Divisions)
- Known projects of interest/best practice covering a range of priority issues and target groups.

The sample group was:

- Campaspe PCP
- Central West Gippsland PCP
- Goulburn Valley PCP
- Hume Moreland PCP
- Inner South East PCP
- Outer East PCP
- Southern Grampians Glenelg PCP
- Upper Hume PCP
- Wimmera PCP.

Data collection methods included:

- Semi-structured interviews and focus groups with senior managers or middle managers from member agencies.  These forums provided the opportunity to consider and discuss the complexities of the local partnerships and the way in which they had supported the implementation of IHP.  Participants were also asked to comment on the benefits and value they received as a result of their investment in the partnership and how this impacted on their agency and its ability to implement IHP initiatives.
- Broad level consultation and semi-structured interviews with other government departments, peak bodies and other relevant stakeholder groups
- A comprehensive questionnaire for agencies in the sample group as well as a shorter questionnaire for agencies from non-sample group PCPs
- Analysis of written reports from health promotion projects and PCP community health plans.

Non-sample group PCPs were able to contribute to the evaluation via a questionnaire survey (short form) or telephone interview.

# Appendix 2: Questionnaire ratings summary

| Statement | Statewide average rating out of 10 |
|---|---|
| The primary care partnership model and approach has been effective in facilitating IHP | 7.4 |
| The partnership approach has resulted in strong, mature inter-agency relationships | 7.7 |
| The number of agencies our agency connects with for health promotion has increased due to the partnership approach | 7.5 |
| The PCP IHP approach has increased the commitment of agencies to IHP | 7.1 |
| Our agency uses an IHP common planning framework | 6.6 |
| IHP is reflected in our agency strategic plan and quality plan | 7.4 |
| We have a comprehensive PCP IHP plan that lists goals and objectives, target groups, interventions, roles, responsibilities and progress indicators | 7.3 |
| Our PCP IHP plan was informed by data and evidence | 7.2 |
| Our PCP IHP plan included consumer and carer  input | 6.4 |
| For the outcomes achieved, the IHP shared approach to planning has saved time | 6.0 |
| How would you rate the overall effectiveness of IHP prior to the PCP IHP strategy | 3.8 |
| How would you rate the overall effectiveness of IHP now  (1= low; 10 = high) | 7.6 |
| The PCP has played a key role in leading and motivating participation in the IHP | 7.4 |
| The PCP approach has helped to build capacity about HP in our agency (e.g.  HP knowledge, skills, commitment, resources) | 7.1 |
| The PCP approach has helped to sustain HP capacity in our agency | 6.7 |
| The PCP IHP approach has improved access to, and allocation of, IHP resources (financial and other) | 7.0 |
| The PCP approach has assisted in the efficient use of resources | 6.8 |
| The PCP IHP approach has improved health promotion workforce development in our agency | 6.8 |
| The PCP IHP approach has helped organisational learning about IHP | 6.1 |
| The PCP IHP approach has improved IHP governance and management structures (e.g.  the way our organisation plans and implements HP | 5.9 |
| The PCP IHP approach has improved coordination of effort (e.g.  through the IHP network communication pathways information sharing) | 7.6 |
| The PCP approach has reduced inefficiencies and duplication between agencies in relation to IHP | 6.5 |
| For consumers, the PCP IHP approach has improved access to health promotion programs, links to disease management programs and information | 7.4 |
| The PCP IHP approach has assisted in improving IHP monitoring and evaluation | 6.4 |
| Our success in IHP has increased as a result of the PCP IHP approach | 6.7 |
| Overall capacity building prior to the PCP IHP strategy (1= low; 10 = high) | 3.8 |
| Overall capacity building now (1= low; 10 = high) | 7.5 |
| Improvement and progress in PCP IHP has been apparent over time | 7.2 |
| Collaborative and integration of PCP health promotion has improved over the last three years | 7.6 |
| This has resulted in a clear and shared focus on agreed priorities | 7.1 |
| PCP IHP has resulted in better quality of IHP e.g. project design, targeting and implementation | 6.8 |
| Overall IHP quality prior to the PCP IHP strategy (1= low; 10 = high) | 3.8 |
| Overall IHP quality now (1= low; 10 = high) | 7.4 |
| The PCP approach has resulted in *tangible* benefits to our agency | 7.2 |
| The PCP approach has resulted in *intangible* benefits to our agency | 6.7 |
| The benefit of being involved in the PCP IHP outweighs any associated costs | 7.1 |
| The PCP approach has added value to IHP in our agency | 7.0 |

# Appendix 3: Agency list (sample group only)

| | |
|---|---|
| Campaspe PCP | Shire of Campaspe |
| | Kyabram and District Health Service |
| | Echuca Regional Health Service |
| | Rochester and Elmore District Health Service |
| | Sportsfocus |
| Central West Gippsland PCP | Latrobe Regional Hospital |
| | Latrobe City |
| | Baw Baw Shire Council |
| | Latrobe Community Health Service |
| | Department of Veteran Affairs |
| | Gippsport |
| | Gippsland Mental Illness Fellowship |
| Goulburn Valley PCP | Cobram District Hospital |
| | Yarrawonga District Health Service |
| | Familycare |
| | Goulburn Valley Community Health Service |
| | Numurkah District Health Service |
| | Gouburn Valley Division of General Practice |
| | Valley Sport |
| | Goulburn Valley Health |
| | Womens Health in the North East |
| Hume Moreland PCP | North West Area Mental Health |
| | Meadow Heights Learning Shop |
| | Moreland Community Health Service |
| | Moreland City Council |
| | Dianella Community Health |
| | Broadmeadows Community Neighborhood Renewal |
| | Sunbury Community Health Centre |
| | Hume City Council |
| ISEPICH | Bentleigh Bayside Community Health Service |
| | Bayside Health/Caulfield Community Health Service |
| | City of Glen Eira |
| | Australian Polish Community Services |
| | Inner South Community Health Service |
| | Monash Division of General Practice |
| | Port Phillip Community Group |
| Outer East PCP | Knox Community Health Service |
| | Ranges Community Health Service |
| | Donwood Aged Care |
| | Melbourne East GP Network |
| | Eastern Access Community Health |
| | Yarra Valley Community Health |
| | Outer East PCP Consumer Reference Group |
| | Women's Health East |
| | Knox City Council |
| | Maroondah City Council |
| | Shire of Yarra Ranges |
| Sothern Grampians Glenelg PCP | Glenelg Outreach Primary Health |
| | Western District Health Service |
| | Old Court House Community Health Centre |
| | Casterton Memorial Hospital |
| | Kyeema Centre |
| Upper Hume | Wodonga Regional Health Service |
| | Indigo North Health |
| | Beechworth Health Service |
| | Women's Health-Goulburn North East |
| | Chiltern and District Health Service |
| | Integrated Primary Mental Health-Upper Hume Region |
| | Indigo Shire |
| | Upper Hume Community Health Service |
| Wimmera | YMCA-Horsham Aquatic Centre |
| | Wimmera Uniting Care |
| | Grampians Community Health Centre-Drug and Alcohol Services, Gamblers Help and Health Promotion workers |
| | Rural North West Community Health |
| | West Wimmera Health Service |
| | Murtoah Neighborhood House |
| | Womens Health in the North East |
| | Dunmunkle Health Service |
| | Wimmera Health Care Group |
| | WestVic Division of General Practice |
| Other organisations | General Practice Victoria |
| | VicHealth |
| | Department of Justice-Gamblers Help |
| | Council of Gamblers Help services |
| | Family Planning Victoria |
| | Municipal Association of Victoria |
| | Department of Victorian Communities |