UPPER HUME PRIMARY
CARE PARTNERSHIP

HEALTH PROMOTION CAPACITY AUDIT

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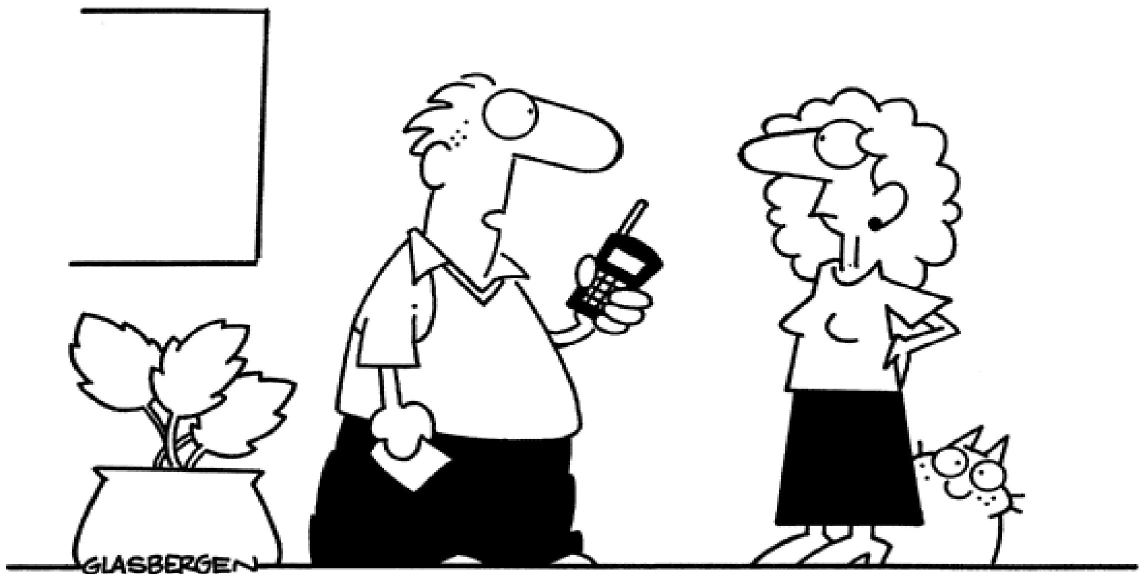

"For the first time in my life, I finally got a high score ...unfortunately, it was my cholesterol test."

2001 to 2004
A Progress Report

Health Promotion Capacity Review: A Progress Report

Published by the Upper Hume Primary Care Partnership, Wodonga, Victoria

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The Health Promotion Capacity Review was carried out between January and October 2004.
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INTRODUCTION

A key objective of the Upper Hume Primary Care Partnership (UHPCP) has been to support the development of health promotion capacity within the partner organisations. Subsequently the UHPCP has been interested to learn if the health promotion capacity of the member agencies has increased or otherwise in the three years since the 2001 review. The UHPCP working group (3) with responsibility for health promotion and service coordination, approached UMHCS to coordinate this second health promotion capacity review as part of a strategy to identify UHPCP's ongoing health promotion development needs.

BACKGROUND

The purpose of the UHPCP has been to define and support the implementation of a range of activities with the capacity to enhance the integration of the primary care sector, in order to improve health and well-being outcomes for local communities. The catchment of the PCP includes the City of Wodonga, the Shires of Towong and Indigo and the Kiewa Valley region of the Alpine Shire.

In 2001, the UHPCP called for expressions of interest to undertake a project to measure the health promotion capacity of its member agencies. The intention was to gain an understanding of the overall health promotion capacity of the UHPCP and to use this information to increase health promotion capacity within the partner agencies.

Under the project management of Working Group 3 and involving all interested partner agencies, the project workers designed and implemented a supported self-assessment strategy based on a self-assessment tool.

The self-assessment tool linked the major theories, relating to health promotion capacity, to three key domains incorporating 17 key elements. Elements within each domain were evaluated using a scale to quantify levels of achievement. Agencies that demonstrated a high level of achievement across the three domains were rated as having a high capacity for health promotion. Since the review was a supported self-assessment process, member agencies produced their own detailed information, which they could choose to use to develop further their health promotion capacity. The overall performance of the UHPCP was determined by the combined performance of the member agencies.

Following the initial review the report was presented to representatives of UHPCP member agencies, Department of Human Services personnel with health promotion and Primary Care Partnership responsibilities. The report contained a number of recommendations relating to the three key domains. Many of these recommendations were taken up by the UHPCP and underpinned the development of core health promotion training and development programs within the sub-region.

PROJECT MODEL

The 2004 process utilised the same self- assessment tool as 2001 to enable a direct comparison between 2001 and 2004. Similar to 2001, the current review process involved partner agencies being provided with the self-assessment tool to complete. Assistance was once again offered to support agencies to identify relevant evidence and to rate their own performance.

The three domains that formed the broad structure of the assessment included: management & governance, practitioners, and the community. The domains were identifiable by settings and stakeholders (See Figure 1). The elements within each of these domains were evaluated with an achievement rating.

DESIGN & METHODS

As described above, the tool, (see Appendix A), was drawn from the best practice literature in 2001. It was developed with the assistance of a number of members through participation in a workshop in April 2001. The tool was developed in a familiar format consistent with health service accreditation self-assessment tools. However, it was understood that processes such as these can be onerous, particularly when they relate to a new area of evaluation. Subsequently, the reviewers were keen for the process to be simplified as much as possible and to add value to each agency, rather than represent an additional burden.

In this second review support was offered over the telephone or via email. A site visit was beyond the scope of the project, this time around, and was considered less important since it was a repeat audit. Despite reminders and encouragement from UHPCP staff and from the reviewers only 6 partner agencies elected to participate in the 2004 process compared to twenty-three in 2001. It may be advantageous for the UHPCP to survey partner agencies to determine the reason for the poor response. The 6 members participating in 2004 are listed in Table 1.

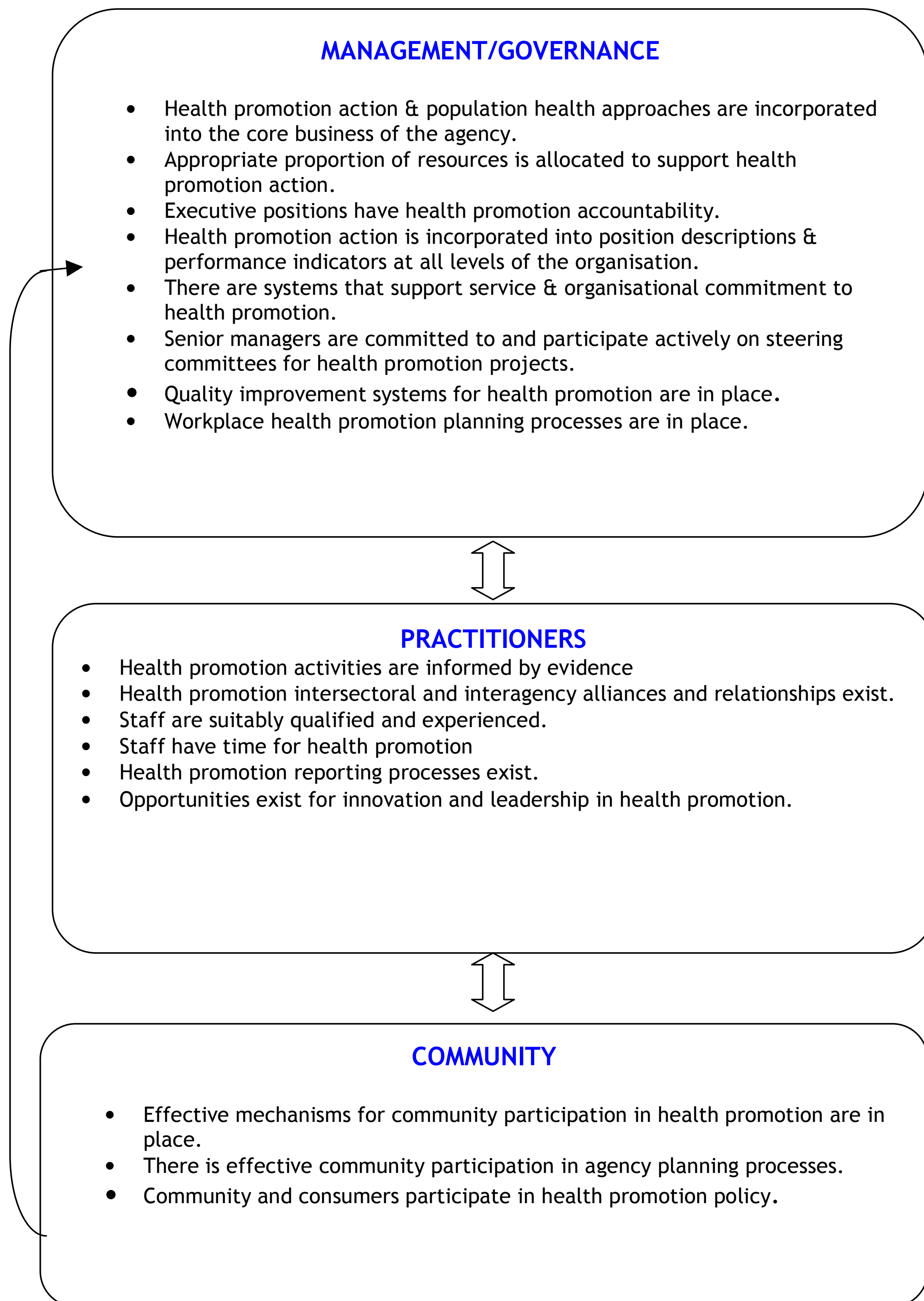
Table 1: List of Participating Members

Participating Members
• **1 Community Health Services** • **3 Small Rural Health Service (1 MPS)** • **1 Regional Health Service** • **1 Regional Advocacy Service** •

How members used the tool depended on how health promotion was structured within the agency and the resources available to undertake activities such as this one. Members used a variety of staff, including health

promotion staff or community services team leaders, to coordinate the completion of the tool.

Figure 1. Model for Determining Health Promotion Capacity of the UHPCP



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

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

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

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

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

Data analysis has focused on identifying the current capacity of the participating agencies to support health promotion in their communities and provide detailed information relating to opportunities to enhance their health promotion capacity. The review has also identified health promotion leading practice within the UHPCP. This information could be used to support partner agencies (through mentoring and other forms of support) with fewer resources to further build their health promotion capacity. To a lesser degree the review has provided information about the ability of the UHPCP, as a partnership, to undertake health promotion activities and support health promotion within its geographic catchment.

FINDINGS & GENERAL ANALYSIS

The small self-assessment response rate has meant that a meaningful analysis between 2001 and 2004 is not possible. Subsequently the review has focused on the 6 agencies that participated in the 2001 and 2004. Unfortunately it is unlikely that these 6 self-selecting agencies would be presentative of the UHPCP. More likely they are agencies that have higher

capacity for health promotion and their participation in this review is a reflection of the value their organisations place on health promotion.

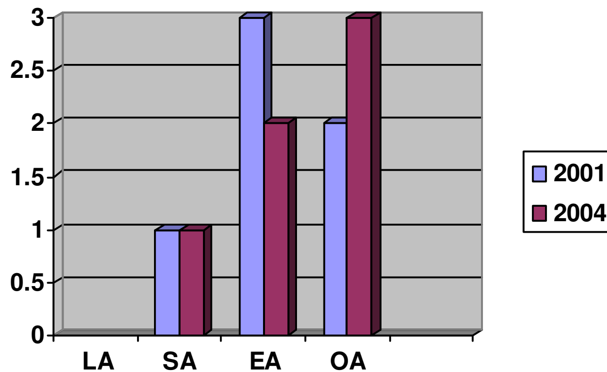
The findings will be presented as:

- a discussion around each indicator
- an overall rating for the 6 participating agencies;
- examples of exemplary structures, practices, knowledge and skills; and
- areas of low performance or opportunities for improvement.

Individual agencies are not identified.

KEY AREA 1. MANAGEMENT AND GOVERNANCE

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



FINDINGS/DISCUSSION:

In 2004 members have self assessed their overall performance in health promotion action and population health approaches as strong. A population health approach is a method that explicitly links interventions to health status. A systematic and collaborative assessment of population needs, designed to identify priority health issues, is undertaken. Determinants and associated risk factors are identified together with information and evidence of methods that strategically act upon health issues.

In 2001 the majority of agencies performed in the extensive range of achievement. Indications of outstanding performance were evident where mission and vision statements reflected primary health care principles and the social model of health. Vision and mission statements such as 'working together for healthy communities' and 'working with our community to promote health and wellbeing' support the notion of health promoting members and reflect a population health approach.

In 2004 at least one agency rated their capacity as lower than in 2001. This was likely due to a different person undertaking the review. It was evident that most agencies have service and business planning processes that respond to identified community needs. For these organisations health promotion strategies reflect evidence of this need and staff have been provided with the skills and resources based on this evidence. Members reported that there is now much more data available to inform their service planning processes. Most recipients viewed the Hume Region Health Promotion Officer as a valued point of access for data and relevant information on evidence based health promotion strategies.

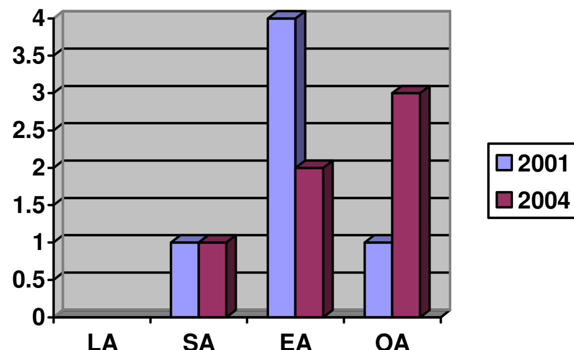
Members also reported increased funding for workforce development for health promotion. All organisations reported health promotion strategies in corporate and service plans with some members, with some having developed organisational performance indicators relating to health promotion.

Participants continued to report that specific service funding and reporting requirements limit innovation and opportunity for health promotion activities. It is still evident in 2004 that where funding is pooled there is increased evidence of health promotion activities.

RECOMMENDATIONS:

- That the UHPCP continue to distribute data and information relevant to population health and wellbeing
- That members be encouraged to link assessed health needs to service & corporate planning processes; and report their performance in implementing their plans back to their community

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



FINDINGS/DISCUSSION:

This indictor is intended to measure the performance of agencies with regard to allocating appropriate resources to health promotion. In terms of the 6 agencies two agencies that were performing well in 2001 are now outstanding performers, making a total of three agencies out the 6 in this leading practice category. All 6 agencies self assessed as having additional resources for health promotion and most agencies had designated health promotion positions.

Similar to 2001, agencies had been resourceful in this area and had added health promotion to the scope of many existing programs.

Most respondents reported an increased awareness of how resources are allocated and how decisions relating to resource allocations are made within their organisations, making it easier to increase the profile of health promotion within their agency.

Members also reported that participation in UHPCP health promotion activities and the regional health promotion training had increased their organisation's capacity for health promotion.

RECOMMENDATIONS:

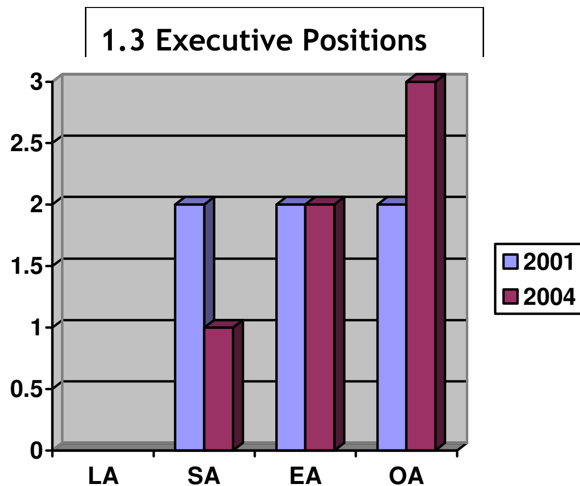
That the UHPCP:

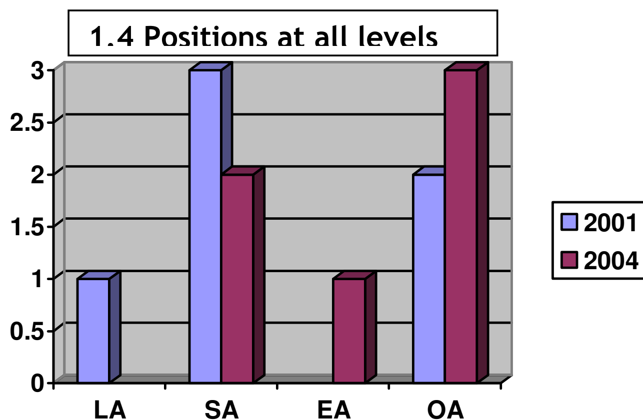
- continue to support the allocation of health promotion resources to agencies to undertake health promotion activities.

That the DHS:

- continue to provide regional training in health promotion.

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





Overall the agencies have demonstrated an improved capacity, not only in terms of senior positions having health promotion accountability, but also with reagrd to positions at all levels having responsibility for health promoting actions. Exemplary examples were evident when members reported 'health promotion is core business at all levels' and that 'health promotion is a standing item at senior management meetings'.

All members participating stated that health promotion was now reflected in most position descriptions and some agencies have health promotion targets and performance indicators linked within certain key roles.

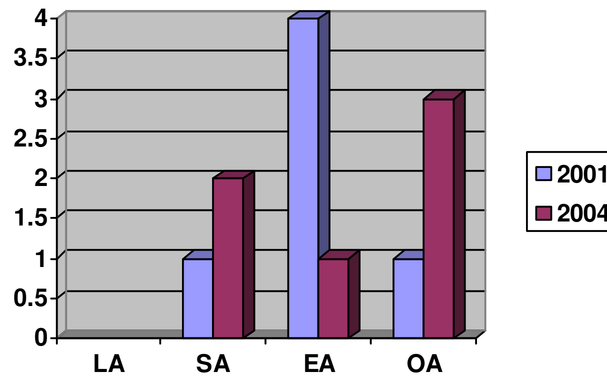
In 2004, most members display outstanding performance in the allocation of responsibility to specific staff for the coordination of staff health promotion programs, in addition to traditional occupational health & safety activities.

Recommendations:

That the UHPCP:

- Support members to continue to develop appropriate health promotion performance indicators at an organisation and senior management level.

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



FINDINGS/DISCUSSION :

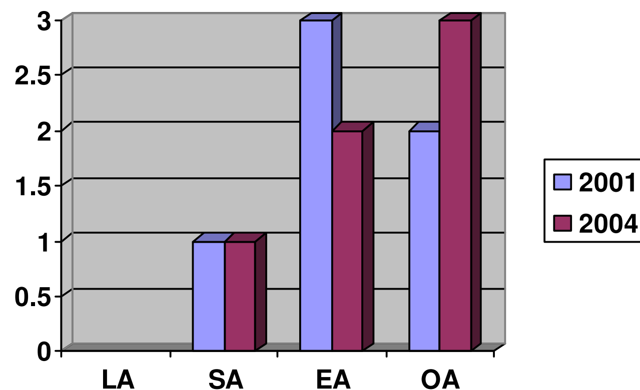
Systems to support health promotion include structures such as: inter and intra agency networks; health promotion committees; strategic, business and service plans; policies, procedures; positions dedicated to health promotion coordination; consumer advocacy; and community participation strategies. The findings highlight an overall increased capacity within the 6 agencies, with the majority of members demonstrating an extensive or outstanding capacity. However, once again at least one agency rated its capacity as less than 2001. The UHPCP Health Promotion and Service Planning Working Group was acknowledged as enhancing the capacity of members to undertake health promotion and was seen as a significant support system in itself by the majority of participants.

RECOMMENDATIONS:

That UHPCP members:

- continue to support the health promotion initiatives undertaken by the Health Promotion and Service Planning Working Group.

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



FINDINGS/DISCUSSION:

As in 2001 agencies that reported a management and board commitment to health promotion, also reported extensive or outstanding levels of achievement in most other areas of the review.

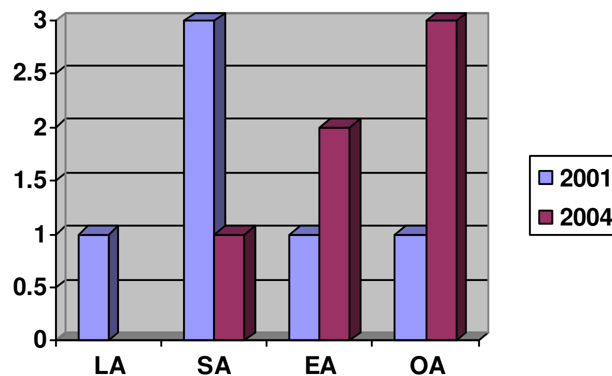
Exemplars of outstanding achievement included senior managers and board members participating on health promotion committees and projects such as the PCP platforms, senior managers providing leadership with regard to community development and consumer participation strategies, board business papers and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

RECOMMENDATIONS:

That the UHPCP:

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

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



FINDINGS/DISCUSSION :

In 2001 the majority of members self-assessed their performance regarding quality improvement systems for health promotion in the lower achievement levels. In 2004 5 out of 6 agencies report an extensive or outstanding capacity with regard to quality improvement systems for health promotion. A number of participants reported using software such as Quality Improvement Program Planning (QIPPS), which leads agencies through a continuous improvement process.

Innovative exemplars included:

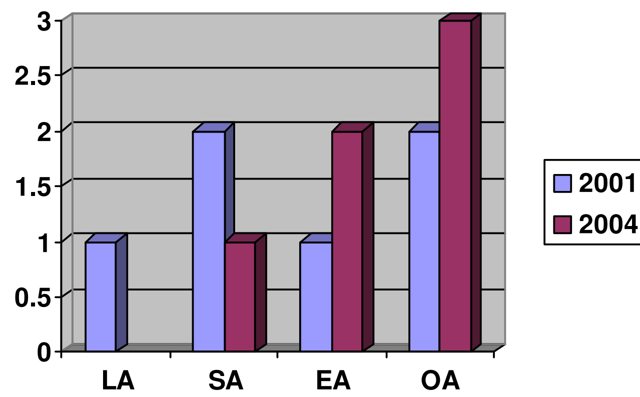
- Evidence based health promotion initiatives to address waiting lists and access to services;
- The use of self- assessment tools such as the National Resource Centre for Consumer Participation in Health Self-Assessment Tool for Consumer Participation, to identify quality improvement priorities and best practice strategies for improvement; and
- Action research projects to enhance the effectiveness of community decision making structures and processes.

RECOMMENDATIONS:

That the UHPCP:

- encourage members to undertake regular reviews utilising the Health Promotion Capacity Self-Assessment Tool to inform their health promotion quality improvement processes; and the National Resource Centre for Consumer Participation in Health Self-Assessment Tool for Consumer Participation, to identify quality improvement priorities and best practice strategies for improvement for consumer participation.

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



FINDINGS/DISCUSSION :

All 6 participating agencies reported improvements in workplace health promotion planning since the review in 2001. All 6 agencies also report to having staff health programs in place. Extensive achievement was evident where member agencies had programs such as walking groups, Yoga and Thai Chi classes, relaxation programs, massage, aerobics, a workplace gymnasium and or fitness programs, social clubs, quit smoking and healthy lifestyle programs, in addition to traditional occupational health and safety programs.

Outstanding achievement reflected a whole of organisation approach, where the overall culture of the organisation supported individuals, teams, and the overall organisation to value health and wellbeing.

The organisations with this type of culture had flat management structures, useful financial and management delegations at all levels of the organisation, flexible work practices, staff health programs and family-friendly environments. Exemplars of flexible work practices included,

flexible working hours, the ability to work from home, flexible use of leave, and flexible policies relating to family and children at work.

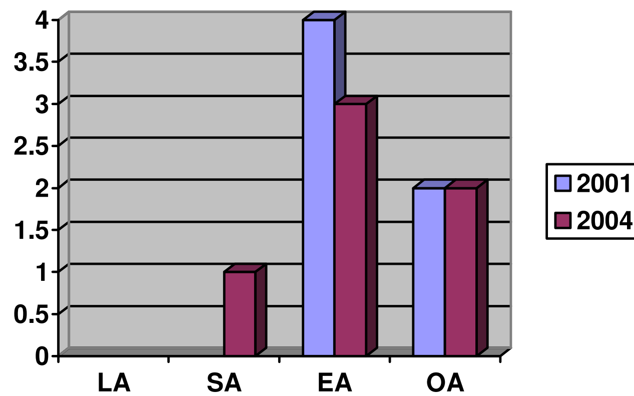
RECOMMENDATIONS:

That the UHPCP

- support health promoting organisational development initiatives as a key learning area for board members and senior staff; and
- develop a training module for organisational development that links organisational development to community development and primary health care principles.

KEY AREA 2. PRACTITIONERS

Indicator 2.1: Health Promotion Activities Are Informed By Evidence.



FINDINGS/DISCUSSION :

Although 1 of the 6 agencies reported less capacity against this indicator in 2004 compared to 2001, in 2004, most participants expressed an improved or more sophisticated understanding of evidence based health promotion processes, interventions and programs

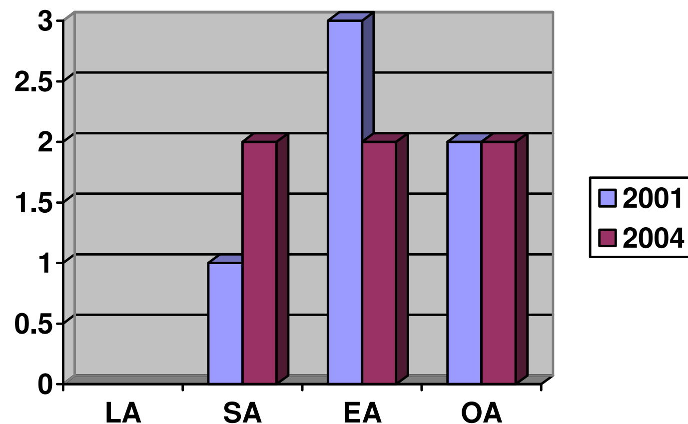
Some members still reported difficulty in accessing the Internet or health promotion journals in their workplace. This was considered a barrier when there is an expectation that all health promotion initiatives are evidence based.

RECOMMENDATIONS:

That the UHPCP:

- support partner agencies to continue to build their capacity to use the best available evidence to inform their health promotion, planning, implementation and evaluation; and
- progress plans to use the IT strategy to enable all health workers to have easy access to the Internet for information purposes.

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



FINDINGS/DISCUSSION:

The findings in this section suggest that there maybe less capacity within the 6 partner agencies for intersectoral and interagency alliances and relationships than 2001. One agency reported the tyranny of distance and the inability to free up staff as a significant inhibitor to even participating in the PCP. The differing priorities between sectors, such as local government and small rural health services, were also reported as an area that challenged intersectoral and interagency collaboration.

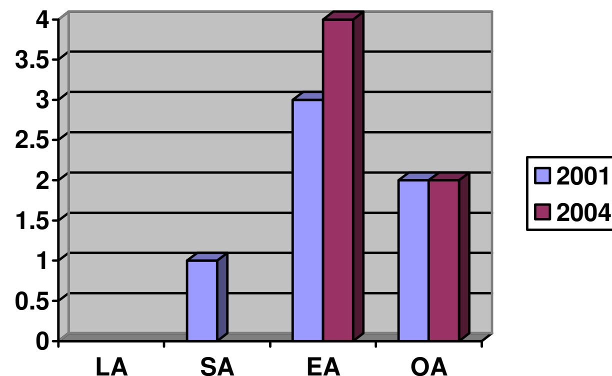
Despite this the UHPCP Working Group 3 was identified as the key driver in developing inter-agency processes and structures for health promotion. Members also reported cross border networks and alliances with divisions of general practitioners.

RECOMMENDATIONS:

That the UHPCP:

- continue to support the work of Working Group 3 inter-sectoral and inter agency health promotion initiatives.

Indicator 2.3: Staff Are Suitably Experienced And Qualified.



FINDINGS/DISCUSSION :

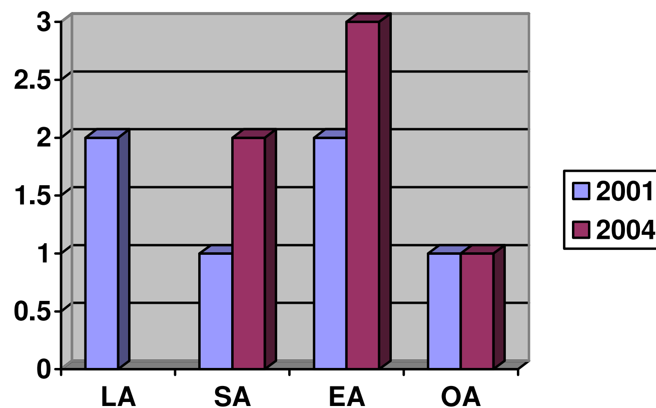
The commitment shown from the UHPCP with support from the Department of Human Services to increase training opportunities in health promotion is reflected through increased capacity in this area. All 6 participant members reported extensive achievements with regard to health promotion training and development within their organisations. Specialist health promotion staff were reported to be suitably experienced and qualified to provide and support health promotion initiatives. Agencies reported up to 60% of staff attending the DHS Health Promotion Course and over 90% of staff undertaking the Mental Health First Aid course. Other members reported various staff with postgraduate health promotion qualifications.

RECOMMENDATIONS:

That the UHPCP:

- continues to lobby the DHS to facilitate and support local skills-based health promotion courses accessible and relevant to rural practitioners; and
- acknowledges the need for all health workers to add value to their practice by understanding and applying the principles of primary health care.

Indicator 2.4: Staff Have Dedicated Time For Health Promotion.



FINDINGS/DISCUSSION :

All members self-reported dedicated time for health promotion, unlike 2001 when members stated that dedicated time was limited. However, participants once again expressed concern over the difficulties they experience in achieving a balance between dedicated health promotion activities and other competing priorities.

As in 2001, members reported being restricted by funding and reporting guidelines, which often do not allow for health promotion activities.

Agencies with dedicated staff for health promotion and community development reported higher levels of performance against this indicator.

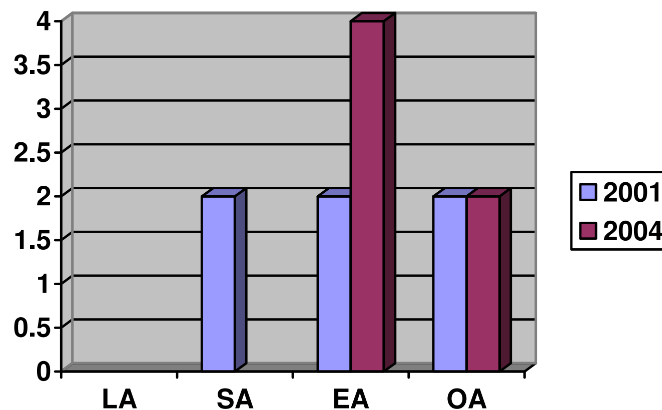
RECOMMENDATIONS:

That the UHPCP again:

- continue to lobby the Department of Human Services to acknowledge the importance of health promoting activities at all levels of service provision, and to reflect this understanding in their funding guidelines; and

- continue to support partner agencies to utilise funding flexibly to pool health promotion resources for the purposes of establishing dedicated health promotion & community development positions and or allocate time and resources for all staff to participate in health promoting activities.

Indicator 2.5: Health Promotion Reporting Processes Are In Place.



FINDINGS/DISCUSSION :

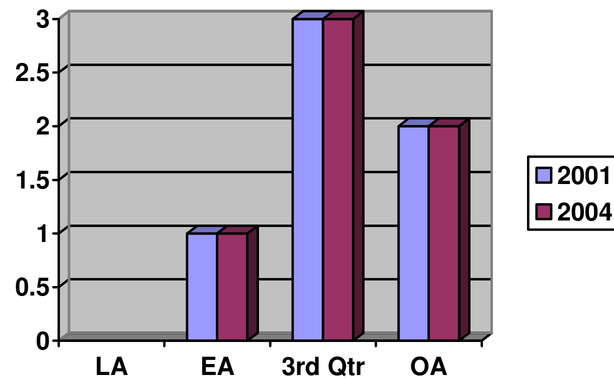
Intra agency health promotion reporting has progressed significantly as a result of the implementation of the Department of Human Services and PCP reporting process. Intra agency reporting is occurring at a number of levels ranging from intranet reports, business plans, newsletters and as highlights in annual reports. Those reporting the highest capacity against this indicator had policies and procedures that enabled consistent reporting and specialised software support such as QIPPS. The reports scoped planning, intervention and evaluation processes.

RECOMMENDATIONS:

That the UHPCP:

- continue to support, through education and training, and consultation with practitioners, the development of minimum standards in health promoting reporting.

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



FINDINGS/DISCUSSION:

In 2004, the organisations with a strong capacity for health promotion reported high levels of staff support processes, where staff felt they were acknowledged for their leadership and innovation at both service and senior management level. This included feedback at meetings and recognition of staff training and development needs. Leadership was also evident where devolved and shared decision making processes existed around resource allocation decisions.

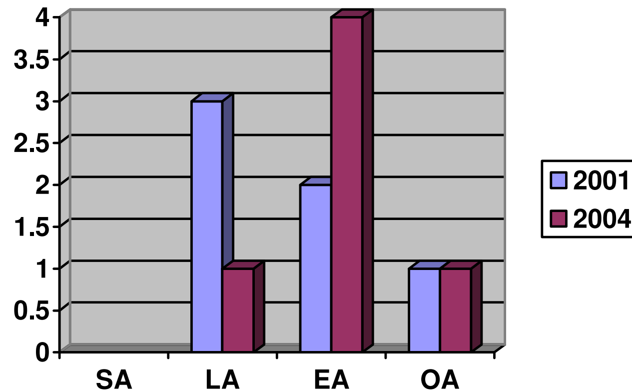
RECOMMENDATIONS:

That the UHPCP:

- support and encourage leadership development within the partner agencies.

KEY AREA 3. COMMUNITY PARTICIPATION

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



FINDINGS/DISCUSSION :

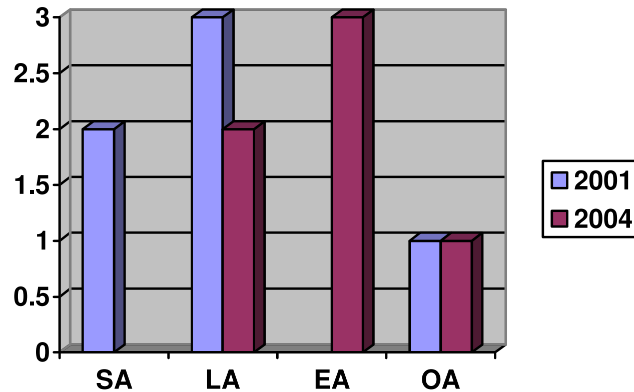
Despite participants reporting significant achievements against this indicator, most members reported little progress in relation to engaging consumers in the planning and development of health promotion programs.

Participants stated that they used service provider groups and boards of management as the main source of consumer participation to inform program development.

Where participants reported outstanding achievement they generally engaged consumers in all areas of their operations, including health promotion planning processes. In addition, outstanding performers had the flexibility to respond to individuals and groups, as well as demonstrating that they have a very good understanding of their community of interest.

The recommendations for community participation have been summarised in 3.3.

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



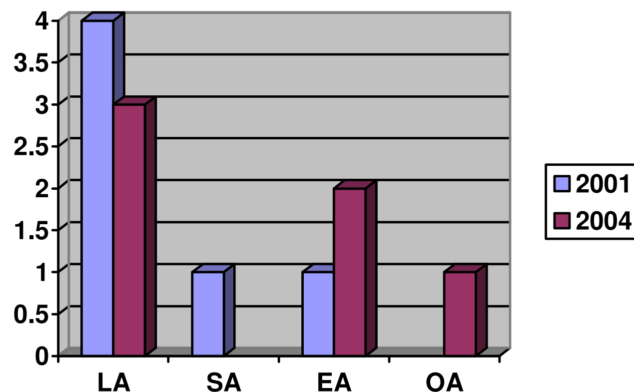
FINDINGS/DISCUSSION :

As in 2001, consumer participation in agency planning activities, varied across the UHPCP, with most reporting some achievement in this area. Participants reported using consumer surveys, existing committees and board activities as consumer participation strategies. Most partner agencies reported that this area as one requiring further development and improvement.

Exemplars of effective consumer participation were evident where agencies had supported and trained representative groups to participate in all levels of agency planning, including corporate, service, and program planning. Other exemplar strategies included having consumers on quality management teams, consumer reference groups to inform various programs and nominated consumer advocates.

Others reported using the National Resource Centre for Consumer Participation in Health Self-Assessment Tool for Consumer Participation as a useful instrument to identify best practice strategies for consumer participation and to support continuous improvement in this area.

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



FINDINGS/DISCUSSION :

In 2001 and 2004 members mostly reported underachievement in this area. Where members did not have effective mechanisms for consumer participation, they had little ability for consumers to influence agency policies.

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

RECOMMENDATIONS:

That the UHPCP:

- utilise the consumer participation project findings to initiate strategies to further develop members capacity for consumer participation
- encourage partner agencies to use the National Resource Centre for Consumer Participation in Health Self-Assessment Tool for Consumer Participation, to support continuous improvement in this area.

SUMMARY OF FINDINGS

The 2004 review has clearly shown a significant increase in the capacity of the 6 participating agencies to undertake health promotion. Health promotion has progressed strongly in each of the governance, management and service provider domains. In each domain participants self assessed extensive or outstanding achievement against the majority of indicators. The domain that has been self- assessed as requiring a significant focus was consumer participation. Most members reported the need for improved strategies for engaging consumers and their communities.

In this regard, agencies that have participated in the review, once again, have the opportunity to use the information provided through the self-assessment tool to support continuous improvement in health promotion.

Participants acknowledged the Upper Hume PCP and particularly Working Group 3, as having a positive impact on their capacity to undertake health promotion. The UHPCP was also acknowledged for providing leadership and support for health promotion training and for enabling partner agencies to access demographic and health data in addition to information relating to effective health promotion interventions and leading practice. The Department of Human Services was also acknowledged for the supported provided, particularly through the regional office.

The recommendations have been organised within the framework utilised in the 2001 review. At that time the Department of Human Services (DHS) Primary Care Partnerships – Draft Health Promotion Guidelines 2000, identified five key action areas for building capacity to promote health. These are Organisational Development, Resource Allocation, Workforce Development, Leadership and Partnerships. The recommendations have been placed within the key action areas for purposes of consistency of reporting.

Organisational Development Recommendations:

That the UHPCP

- encouraged members to link assessed health needs to service & corporate planning processes; and report their performance in implementing their plans back to their community;
- Support members to continue to develop appropriate health promotion performance indicators at an organisation and senior management level;
- encourage members to undertake regular reviews utilising the Health Promotion Capacity Self-Assessment Tool to inform their health promotion quality improvement processes; and the National Resource Centre for Consumer Participation in Health Self-Assessment Tool for Consumer Participation, to identify quality improvement priorities and best practice strategies for improvement for consumer participation;
- support health promoting organisational development initiatives as a key learning area for board members and senior staff;
- develop a training module for organisational development that links organisational development to community development and primary health care principles;
- support partner agencies to continue to build their capacity to use the best available evidence to inform their health promotion, planning, implementation and evaluation;
- progress plans to use the IT strategy to enable all health workers to have easy access to the Internet for information purposes;
- utilise the consumer participation project findings to initiate strategies to further develop members capacity for consumer participation; and
- encourage partner agencies to use the National Resource Centre for Consumer Participation in Health Self-Assessment Tool for Consumer Participation, to support continuous improvement in this area.

Workforce Development Recommendations:

That the DHS

- continue to provide regional training in health promotion.

That the UHPCP

- continues to lobby the DHS to facilitate and support local skills-based health promotion courses accessible and relevant to rural practitioners; and
- acknowledges the need for all health workers to add value to their practice by understanding and applying the principles of primary health care.

Resource Allocation Recommendations:

That the UHPCP

- continue to support the allocation of health promotion resources to agencies to undertake health promotion activities;
- continue to support the health promotion initiatives undertaken by the Health Promotion and Service Planning Working Group; and
- continue to support the work of Working Group 3 inter-sectoral and inter agency health promotion initiatives.

Leadership Recommendations:

That the UHPCP

- continue to distribute data and information relevant to population health and wellbeing; and
- continue to take a lead role with regard to developing strategies to demonstrate the value of health promoting activities to senior management and boards.

That the UHPCP again:

- continue to lobby the Department of Human Services to acknowledge the importance of health promoting activities at all levels of service

provision, and to reflect this understanding in their funding guidelines; and

- continue to support partner agencies to utilise funding flexibly to pool health promotion resources for the purposes of establishing dedicated health promotion & community development positions and or allocate time and resources for all staff to participate in health promoting activities.

That the UHPCP:

- continue to support, through education and training, and consultation with practitioners, the development of minimum standards in health promoting reporting.
- support and encourage leadership development within the partner agencies.

CONCLUSION

The purpose of the 2004 Health Promotion Capacity Review was to identify any change in the capacity of partner agencies in Upper Hume Primary Care Partnership (UHPCP) to undertake health promotion and to provide a vehicle for individual agencies and the UHPCP to continue to develop capacity for health promotion. For the purpose of reliability the 2004 process utilised the same self- assessment tool as 2001.

Despite agencies being offered support to complete the self-assessment tool, only 6 agencies chose to participate. In the main, these agencies were high performing agencies in 2001.

What is important is that these agencies have continued to increase their capacity to deliver effective health promotion programs, strategies and interventions and in many cases can demonstrate leading practice.

These agencies represent a significant regional resource that should be used to support other partner agencies to build their capacity for health promotion.

The reviewers also believe it is important for this report to acknowledge the support consistently offered to partner agencies, by the UHPCP, to build their capacity by undertaking projects or programs on behalf of the partnership, rather than utilising external consultants.

APPENDIX A

UPPER HUME PRIMARY CARE PARTNERSHIP –

WORKING GROUP 3

HEALTH PROMOTION PROJECT

Health Promotion Capacity Self Assessment Tool

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INTRODUCTION

Upper Murray Health & Community Services (UMHCS) has been invited to repeat the Health Promotion Capacity Review undertaken in 2001. The aim is to compare the capacity of the Upper Hume PCP for health promotion in 2003 compared to 2001 when the initial audit was undertaken. A significant number of health promotion strategies have been undertaken in the past 2 years, led in the main by the Upper Hume PCP Working Group 3, which is responsible for Health Promotion and Service Coordination. Working Group 3 approached UMHCS to coordinate this second health promotion capacity audit as part of its strategy to identify Upper Hume PCP's ongoing health promotion development needs.

Health promotion has changed significantly from its origins based on relatively simple models of individual behaviour change to more complex multi factorial and multi sectoral approaches.

UMH&CS has linked the theories around health promotion capacity with the outcomes for the UHPCP Health Promotion project. The self assessment tool is based on a set of health promotion domains which are identifiable by settings, stakeholders and mechanisms within an organisational development framework. Elements within each domain, which highlight health promotion infrastructure, are evaluated using a set or ratings to quantify health promotion capacity.

The tool, drawn from the best practice literature, has been developed with the assistance of a number of member agencies in April 2001. Whilst, the tool is in a familiar format, consistent with health service accreditation self- assessment tools, we understand that they can be onerous, particularly when they relate to a new area of evaluation.

Subsequently we are keen for the process to simplified as much as possible and to add value to your operations, rather than represent an additional burden.

Information relating to individual agencies *will not be identified* in the final report. The report will be an overview of the Upper Hume Primary Care Partnership's ability to undertake health promotion.

DEFINITION AND MODEL

The definition of health promotion capacity that has been used in the development of the tool is a system that involves the development of sustainable skills, organisational structures, resources and commitment to health improvement to prolong and multiply health gains many times over (NSW Health in DHS 2000, 32).

The three domains that are being reviewed are: Management & Governance, Practitioners and Community.
The domains as identifiable by settings and stakeholders. The elements within each of these domains are evaluated. A rating, as explained below, is assessed by yourself or your team.

HOW TO USE THE SELF ASSESSMENT TOOL

How you use this tool depends on how health promotion is structured in your agency and the resources you have available to undertake activities such as this. Agencies may use Quality Improvement/Coordinator staff, health promotion staff or community services team leaders to coordinate the completion of the tool, with each department/unit being responsible for completing their own areas.

Please complete all indicators as comprehensively and concisely as possible. Do not sell the PCP short by not providing comprehensive information. Give several examples of activities, services, programs, agencies etc wherever possible. Specify polices where these exist, or where they are in other documents.

RATING THE RESULTS

Each of the elements/indicators has a rating based on the EQuIP format.
Outstanding Achievement (OA) – where the agency has demonstrated that it has achieved all the requirements of the elements/indicators, and that it has done additional work to expand the implementation of the element/indicator;
Extensive Achievement (EA) – where a agency has demonstrated that it has achieved most of the requirements of the indicator/element;
Some Achievement (SA) – where a agency can demonstrate that it is attempting to achieve the requirements of the elements/indicators.
Little Achievement (LA) – where a agency has not attempted to achieve the elements/indicators.
Not Applicable (NA) – where the service can demonstrate that it cannot attain the level required due to it being prohibited by legislation or by funding, policy or guidelines.

WHAT TO DO WITH THE RESULTS

Once the information is gathered, UMH&CS would appreciate being provided with the original copy. This information will then be utilised to inform the final report. Information relating to individual agencies will not be identified in the final report. The report will be an overview of the increased capacity of the Upper Hume Primary Care Partnership's to undertake health promotion.

You are encouraged to take the opportunity to use the information for continuous improvement purposes. We would welcome any feedback agencies may have about the tool including its use

Thank you for your participation

DATA BASE SHEET

NAME OF SERVICE

ADDRESS

PHONE	**FAX**	**EMAIL**

MANAGER/CEO

CONTACT PERSON	**POSITION**

PHONE	**FAX**	**EMAIL**

TYPE OF SERVICE eg. Hospital/ Local Government/Community Health Service/MPS/Health Streams

CORE SERVICES OFFERED

CATCHMENT AREA – GEOGRAPHIC MAIN CENTRE

DATE of COMPLETION

Key Area #1 Management and Governance					
	Elements/Indicators (structures, resources processes, mechanisms)	**Examples of achievement**	**How does your service achieve this element/indicator Include/list examples**	**Rating: LA, SA, EA, OA, N/A**	**Areas/strategies to enhance health promotion capacity (optional)**
1.1	Health Promotion (HP) action & population health approaches are incorporated into the core business of the agency.	Health promotion (HP) is evident in or by the following processes: • mission statement or organisational values; • corporate & service planning processes; • staff professional development plan (staff training needs for health promotion are identified); • HP strategies respond to evidence of local health and well-being needs.			
1.2	Appropriate proportion of resources are allocated to support health promotion action.	• Resources assigned to health promotion. Eg. Positions, time, funded projects etc. • List how practitioners are aware of allocated funds & how decisions are made around the distribution.			

Key Area #1 Management and Governance cont.					
	Elements/Indicators (structures, resources processes, mechanisms	**Examples of achievement**	**How does your service achieve this element/indicator Include examples**	**Rating: LA, SA, EA, OA, N/A**	**Areas/strategies to enhance health promotion capacity (optional)**
1.3	Executive positions have Health Promotion accountability	• Managers understand & value health promotion. • Management support and recognise the requirements of health promotion staff. • Health promotion outcomes appear in manager's performance agreements. • BOM understanding and support of Health Promotion			
1.4	Health promotion action is incorporated into position descriptions & performance agreements at all levels of the organisation.	• Health promotion is included in position descriptions and performance agreements.			

Key Area #1 Management and Governance cont.

	Elements/Indicators (structures, resources processes, mechanisms	**Examples of achievement**	**How does your service achieve this element/indicator Include examples**	**Rating: LA, SA, EA, OA, N/A**	**Areas/strategies to enhance health promotion capacity (optional)**
1.5	There are systems that support service & organisational commitment to health promotion.	• Structures such as health promotion committees exist. • Policies support health promotion decisions. • Municipal Health Promotion Committee • Community Advisory Group • OHS Committees • Networks • Service Planning			
1.6	Senior managers are committed to and participate actively on steering committees for health promotion projects. BOM identify with and have a commitment to health promotion projects.	• Senior managers participate on health promotion committees/projects • Senior managers bring issues, projects and feedback on HP activities to BOM agendas			

Key Area #1 Management and Governance cont.

	Elements/Indicators (structures, resources processes, mechanisms	**Examples of achievement**	**How does your service achieve this element/indicator Include examples**	**Rating: LA, SA, EA, OA, N/A**	**Areas/strategies to enhance health promotion capacity (optional)**
1.7	Quality improvement systems for health promotion are in place	• Best practice tools guide health promotion work eg. QICSA, competency based standards or capacity building indicators. • Evaluations of HP activities are conducted. • QA planning is incorporated into HP planning			
1.8	Workplace health promotion planning processes.	• Workplace health promotion strategies & resources in place. Please list			

Key Area #2 Practitioners					
	Elements/Indicators (structures, resources processes, mechanisms	**Examples of achievement**	**How does your service achieve this element/indicator Include examples**	**Rating: LA, SA, EA, OA, N/A**	**Areas/strategies to enhance health promotion capacity (optional)**
2.1	Health promotion activities are informed by evidence. (eg. Local evidence, research based evidence)	• Evidence based health promotion strategies in place. List examples. • List sources of evidence • How do local needs translate into a HP activity?			
2.2	Health promotion Intersectoral, interagency alliances and relationships exist.	• Staff are part of multi disciplinary interagency health promotion committees and networks. • Staff participate on external and cross sector planning and action processes.			

Key Area #2 Practitioners cont.					
	Elements/Indicators (structures, resources processes, mechanisms	**Examples of achievement**	**How does your service achieve this element/indicator Include examples**	**Rating: LA, SA, EA, OA, N/A**	**Areas/strategies to enhance health promotion capacity (optional)**
2.3	Suitably experienced and qualified staff	• Staff have relevant qualifications and skills • Information on health promotion courses & conferences is disseminated to staff. • Staff development for health promotion available • Relevant access to journals/internet • Access to evidence based information.			
2.4	Dedicated time for health promotion	• Staff have time allocated for program planning, delivery and evaluation			

Key Area #2 Practitioners cont.					
	Elements/Indicators (structures, resources processes, mechanisms	**Examples of achievement**	**How does your service achieve this element/indicator Include examples**	**Rating: LA, SA, EA, OA, N/A**	**Areas/strategies to enhance health promotion capacity (optional)**
2.5	Health promotion reporting processes (intra-agency)	• Documentation available to support HP programs • There are medical/program records for health promotion activities • Activities are reported in agency newsletters/media etc.			
2.6	Opportunities for innovation and leadership in health promotion.	• How are the staff supported & acknowledged for dedication and leadership in HP. (This might also include mentoring, workforce development, workplace HP activities)			

Key Area #3 Community

	Elements/Indicators (structures, resources processes, mechanisms	Examples of achievement	How does your service achieve this element/indicator Include examples	Rating: LA, SA, EA, OA, N/A	Areas/strategies to enhance health promotion capacity (optional)
3.1	Effective mechanisms for community participation in health promotion	• Community members, user groups, support groups are involved in health promotion planning processes. • Needs of specific groups are responded to. • Staff are available to respond to community/individual requests for health promoting activities. • Community of interest is understood and recognised			
3.2	Proven effective community participation in agency planning processes	• Mechanisms exist for consumer participation in agency planning processes			

Key Area #3 Community					
	Elements/Indicators (structures, resources processes, mechanisms	**Examples of achievement**	**How does your service achieve this element/indicator Include examples**	**Rating: LA, SA, EA, OA, N/A**	**Areas/strategies to enhance health promotion capacity (optional)**
3.3	Community/consumer participation in health promotion policy development	• Policies are distributed to consumers for comment and input.			