Impact evaluation of a comprehensive primary health care reorientation strategy with a focus on organisational development on a health service’s capacity to deliver comprehensive primary health care

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Abstract

Issue: Since 1978, the World Health Organisation (WHO) has consistently advocated for health services to adopt a Comprehensive Primary Health Care (CPHC) approach to address complex health issues and inequities. However, there has been limited uptake of the CPHC approach by health services nationally or internationally. In 2007, the Australian Government recognised the need to increase health services’ capacity to deliver CPHC and made CPHC reform a policy priority. The National Primary Health Care Strategy (2009) is Australia’s first national policy statement and strategy for CPHC. One of the key reform initiatives was the development of Primary Health Care Organisations (PHCOs); named Medicare Locals by the Australian Government. The aim of PHCOs is to provide CPHC to local communities and will evolve from the current Divisions of General Practice Network. PHCOs will be implemented in 2011 and be required to reorient their services to deliver CPHC. Access to information that provides clear steps on how a health service can plan, implement and evaluate a reorientation strategy is critical. In 2008 Far North Queensland Rural Division of General Practice (FNQRDGP) sought to learn how it could reorient its services to deliver CPHC. A CPHC Organisational Development Strategy (ODS) was developed, implemented and evaluated from April 2008 to June 2009.

Aim: The aim of the research was to determine the impact of the Comprehensive Primary Health Care Organisational Development Strategy (CPHC ODS) on FNQRDGP’s capacity to deliver CPHC.

Research question: The research question asked: What is the impact of a CPHC ODS on the capacity of FNQRDGP to deliver CPHC?

Research Design: This research was positioned within a constructivist epistemology, the theoretical perspective was critical theory and the research methodology was impact evaluation. A questionnaire and semi-structured individual interviews were used to collect and analyse quantitative and qualitative
impact evaluation data from 13 participants, across three time points, in reference to organisational capacity components, subcomponents and indicators.

**Results:** From the pre to post impact evaluation time points, mean scores for 31 of the 37 indicators had statistically significant increases, with effect sizes for the increases ranging from moderate to nearly perfect. The majority of indicators had large or very large increases. Twenty nine (78%) of the indicators had significant increases from a lower category at the pre time point to the *High Performing* category at the post time point. Twelve of the indicators (32%) shifted from *Reactive* to *High Performing*, two (5%) shifted from *Reactive* to *Proactive* and 17 (46%) shifted from *Proactive* to *High Performing*. These results indicate that the CPHC ODS increased FNQRDGP’s capacity to deliver CPHC.

Key enablers identified as being necessary to increase FNQRDGP’s capacity to deliver CPHC were: 1) dedicated leadership for CPHC teams with experience in and commitment to CPHC practice; 2) managers with health promotion background and acknowledgement of broad health determinants; 3) CPHC values and principles embedded in all aspects of the organisation’s functions; 4) health promotion theory and resources embedded within all areas and levels of the organisation; 5) whole of team professional development opportunities with a focus on health promotion and CPHC values and principles; 6) whole-of-team understanding about how to apply health promotion to enable CPHC practice; 7) dedicated whole-of-team time to reflect and evaluate organisation’s actions across CPHC continuum; 8) value for and support to conduct community engagement processes; 9) team structure reflects horizontal network compared to a hierarchical structure; 10) being listened to and valued by management by being trusted to use initiative and respected as a professional – feeling empowered and able to make a difference.

Key barriers identified as limiting FNQRDGP’s capacity to deliver CPHC were:
1) not having a whole-of-organisation process to be accountable to communities’ identified priorities; 2) guidelines and deliverables attached to program funding; 3) competitive nature of funding between health services; 4) changes in the external environment that can impact negatively on morale; and 5) partnerships with key stakeholders that are not based on CPHC values and principles.

**Conclusion:** Overall research findings indicated that the CPHC ODS increased FNQRDGP’s capacity to deliver CPHC. Therefore implementing an ODS has the potential to positively impact on an organisation’s capacity to deliver CPHC. Health services involved in reorienting towards CPHC should consider using an ODS to achieve the desired changes. Attention to the barriers and enablers of capacity to deliver CPHC will assist the change process. Efforts to reorient services to CPHC should be evaluated in order to enhance their value to the organisation and to the field of primary health care.
Statement of originality

This work has not previously been submitted for a degree or diploma in any university. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made in the thesis itself.

Michelle Costello
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1.0 Introduction

Since 1978, the World Health Organisation (WHO) has consistently advocated the need for health services to adopt a Comprehensive Primary Health Care (CPHC) approach to address complex health issues and inequities. WHO recognises that the central CPHC values and principles of achieving social justice, the right to better health for all, participation and solidarity are key to achieving such outcomes.\(^1\)\(^-\)\(^7\) However, there has been limited uptake of the CPHC approach by health services internationally and nationally.\(^6\)\(^,\)\(^8\)\(^-\)\(^10\)

Many health services continue to focus on biomedical conditions and risk behaviours in isolation from a much broader range of interrelated political, social, economic, cultural and physical environmental determinants of health.\(^8\)\(^,\)\(^11\)\(^-\)\(^15\) For example, population increase, climate change, food insecurity, social inequities, political unrest, and unequal distribution of wealth are well recognised as having implications for health, yet receive little to no attention from most health services.\(^6\)\(^,\)\(^8\) This narrow focus is attributed to the dominance of the biomedical health paradigm, which determines the selection and resourcing of health priorities and programs.\(^11\)\(^,\)\(^16\)\(^-\)\(^18\) This in turn limits the capacity of health services to deliver CPHC as defined by the WHO.\(^1\)\(^,\)\(^5\)\(^,\)\(^6\)\(^,\)\(^16\)\(^,\)\(^19\)

In 2007, the Australian Government recognised the need to increase health services’ capacity to deliver Primary Health Care (PHC) and made CPHC reform a policy priority.\(^20\)\(^,\)\(^21\) The National Primary Health Care Strategy (2009) is Australia’s first national policy statement and strategy for PHC. One of the key reform initiatives was the development of Primary Health Care Organisations (PHCOs); named Medicare Locals by the Australian Government.\(^9\)\(^,\)\(^20\)\(^,\)\(^22\) The aim of PHCOs is to provide CPHC to local communities and will evolve from the current Divisions of General Practice Network. PHCOs will be implemented in 2011 and be required to reorient their services to deliver CPHC. Given that health services around the world have struggled with calls to reorient their services towards the delivery of CPHC, it is critical that the Divisions in the Network are supported in this process. Access to
information that provides clear steps on how a health service can plan, implement and evaluate a reorientation strategy is critical.\textsuperscript{17, 23-26}

In 2008 Far North Queensland Rural Division of General Practice (FNQRDGP) sought to learn how it could reorient its services to deliver comprehensive primary health care (CPHC). FNQRDGP’s Cape York PHC programs were funded to provide PHC services to eight rural and remote Indigenous communities in Queensland’s Cape York. Teams that visited communities consisted of the following: medical officer; physiotherapist; psychologist; dietitian; podiatrist; diabetes educator; health promotion officer and Indigenous community engagement coordinator. The aim of the PHC programs was to improve the health outcomes of Cape York residents by providing this range of services using a PHC approach.

Despite being philosophically committed to PHC practice, FNQRDGP had no formal organisational strategies to guide such practice. The majority of staff employed in the organisation had studied a traditional clinical health model which does not provide a basis for understanding or addressing complex social community needs and issues. The majority of work reflected a clinical / treatment focus. In general, the organisation determined that staff lacked knowledge, skills, confidence and awareness of PHC values, principles and practices.

FNQRDGP’s health professionals working in Cape York identified the need to develop strategies that better addressed broad community health needs. A health paradigm that better considered the complex interrelationships of social, economic, cultural, and political determinants impacting on people’s health and wellbeing was needed. Management subsequently demonstrated support to reorient PHC organisational practice to better align with its holistic, ecological and salutogenic health philosophy. In its attempt to reorient organisational practice to PHC, FNQRDGP recruited a Primary Health Care Manager. The manager, who is also the principal researcher for this project, commenced research into how the
organisation could reorient to comprehensive PHC (CPHC) delivery. A CPHC-focused Organisational Development Strategy (ODS), with a focus on organisational change, was developed, implemented and evaluated from April 2008 to June 2009.

The purpose of this thesis is to report on the impact of the CPHC ODS on FNQRDGP’s capacity to deliver CPHC. The thesis is organised into six chapters. Chapter two reviews the literature with a focus on understanding how a health service can increase its capacity to deliver CPHC. Section one provides an overview of PHC, the renewed interest in PHC, the current state of PHC reform, and health promotion as a strategy to reorient organisations to deliver CPHC. Section two reviews existing health service reorientation frameworks and case examples including: organisational capacity building; organisational change; and organisational development.

Chapter three describes the research design including: the research aim; research question and sub-questions; epistemology; theoretical perspective; methodology; theoretical frameworks and CPHC ODS; research participants; data collection and analysis methods; and ethics.

Chapter four presents the results of the impact evaluation of the CPHC ODS. It commences with a description of research participants, followed by the results for each of the three research sub-questions. This includes results related to the impact of the CPHC ODS on: 1) Workforce Development Processes; 2) Organisational Processes; and 3) Organisational Culture. The results for the overall research question are then presented.

Chapter five presents a discussion of the results. Results are discussed in relation to the literature and the three components of the CPHC ODS: 1) workforce development; 2) organisational processes; and 3) organisational culture. A range of enablers and barriers within and across the three components that impact on an
organisation’s capacity to deliver CPHC are identified. A summary of key discussion points for each CPHC ODS component is provided. Chapter five also discusses the strengths and limitations of the research.

Chapter six presents the conclusion for the research project and recommendations for future research, practice and policy.

The Appendices include the: Health Promoting Health Services – Organisation and Activities Assessment Tool\textsuperscript{25}; Organisational prototype\textsuperscript{27}; ethics confirmation; Capacity Indicator Framework to Assess Organisational Capacity to Deliver Comprehensive Primary Health Care; CPHC ODS activities; recruitment email; research project information sheet; consent to participate in research form; questionnaire; and CPHC ODS activities and the overall results table.
2.0 Literature review

This literature review focuses on understanding how a health service can increase its capacity to deliver CPHC. Section one provides an overview of PHC, the renewed interest in PHC, the current state of PHC reform, and health promotion as a strategy to reorient organisations to deliver CPHC. Section two reviews existing health service reorientation frameworks and case examples including: organisational capacity building; organisational change; and organisational development. The conclusion identifies the research gap and its relevance to the current context of national PHC reform.

2.1 Primary Health Care

2.1.1 Overview of Primary Health Care

PHC is well recognised as a philosophical, strategic and service based approach to health and health care that can address complex health issues.\(^1\) Thirty years ago, the World Health Organisation (WHO) recognised health services need to adopt a PHC approach to address complex health needs. In 1978 WHO and UNICEF convened a major international conference in Alma Ata (former USSR) to discuss how PHC could impact on the broader determinants of health to reduce health inequities.\(^28\) The conference and the resultant *Declaration of Alma-Ata* are now regarded as important milestones in the promotion of world health.\(^1\)

The declaration identifies health as a fundamental human right for which national governments and the international community should be responsible. PHC is described as the key to attaining health for all by the year 2000. Ten principles were cited in the declaration that became the foundation of PHC.\(^1\) The ten principles of the declaration are:

1. Social justice;
2. Equity;
3. Community participation and maximum community self-reliance;
4. Use of socially acceptable and affordable technology;
5. Health promotion and disease prevention;
6. Involvement of government departments other than health;
7. Political action;
8. Cooperation between countries;
9. Reduction of money spent on armaments in order to increase funds for PHC; and
10. World peace.

The Declaration of Alma-Ata defined PHC as:

*Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.*

Rogers and Veale\(^{29}\) identify three elements within WHO’s definition of PHC. They describe the first element as a philosophical approach to health and health care. The second element is described as a set of strategies aimed at creating health care which is consistent with the underlying philosophy. The third element describes the kind of services provided by PHC; as a set of activities and as a level or model of service provision. These elements are summarised in the following extract from *Primary Health Care and General Practice: A scoping report* (2000) National Information Service, South Australia\(^{29}\) and presented in Table 1.
Table 1: Three elements of Primary Health Care

<table>
<thead>
<tr>
<th>Elements of Primary Health Care</th>
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<tbody>
<tr>
<td>Philosophy</td>
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<tr>
<td>- Holistic understanding of health</td>
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<td>- Recognition of multiple determinants of health</td>
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<td>- Community control over health services</td>
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<td>- Health promotion and disease prevention</td>
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<td>- Equity in health care</td>
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<tr>
<td>- Research-based methods</td>
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<tr>
<td>- Accessible, acceptable, affordable technology</td>
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<tr>
<td>Strategies</td>
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<td>- Needs-based planning</td>
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<td>- Decentralised management</td>
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<tr>
<td>- Education</td>
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<tr>
<td>- Intersectoral coordination and cooperation</td>
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<tr>
<td>- Balance between health promotion, prevention and treatment</td>
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<tr>
<td>- Multi-disciplinary health workers</td>
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<td>Services</td>
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<td>- Locally based</td>
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<td>- Well integrated</td>
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<td>- Disease prevention</td>
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<td>- Illness treatment</td>
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<td>- Rehabilitation services</td>
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2.1.1.1 Primary Health Care as a philosophical approach to health and health care

As a philosophical approach to health and health care, PHC is characterised by a holistic understanding of health and wellbeing, rather than the absence of disease.\(^1\)

The presence of good health is dependent upon multiple determinants; health services are important but so too are housing, education, public works, industry, agriculture, communication and other services.\(^1, 8, 28, 30-32\) The health status of communities is both a function of and a reflection of development in communities. The locus of control is important in PHC; health services should reflect local needs and involve communities and individuals at all levels of planning and provision of services.\(^32, 33\) Services and technology should be affordable and acceptable to communities. Through health promotion and preventive care, PHC aims to eliminate causes of ill health.\(^34, 35\) Equity is a crucial part of PHC; health services must strive to address inequity and prioritise services where greatest inequities exist.\(^33, 36\) Finally, PHC should be based upon social, biomedical and health service best practice research in order to provide effective health care.\(^8, 28, 32\)
2.1.1.2 Primary Health Care as a set of strategies
The second element of PHC is strategic, involving a set of strategies to create health care consistent with the underlying philosophy. These strategies include needs-based planning of decentralised health services and offering management to local communities. Education is a key strategy in PHC; through education communities and individuals gain understanding of and control over health issues. Intersectoral cooperation and coordination is another significant part of PHC. This requires cooperation at all levels, from government planning through to local implementation and across traditional departmental boundaries. PHC services require balance between health promotion, preventive care and illness treatment. This is best achieved by the use of a team drawn from a variety of disciplines, not only including medical, and nursing health professionals but also community workers, population health professionals, health promotion workers, and educators.

2.1.1.3 Primary Health Care as a level of service provision
The third element of PHC describes the kind of services provided by PHC, both as a set of activities and as a level or model of service provision. PHC is the first level of health care that is directly accessible to individuals and communities. This means effective PHC must be locally based, in proximity to the places where people live and work. Geographic barriers may be overcome by locally situated service. To be universally accessible PHC services must also be free from financial barriers. As the first level of health care service, PHC services need to be well integrated with the secondary and tertiary health care sectors, in order to provide continuity of care for people across all levels of the health care system. This involves cooperation and communication. PHC services require cooperative efforts from a team of health care providers drawn from a range of disciplines.

2.1.1.4 Selective and Comprehensive Primary Health Care
One year after the Declaration of Alma-Ata in 1978, Walsh and Warren presented ‘Selective Primary Health Care’ (SPHC) as an ‘interim’ strategy to begin the focus
of PHC implementation. They argued that the best way to improve health was to fight disease based on cost-effective medical interventions. Although they acknowledged that the goal set at Alma-Ata was more comprehensive, they contended that its scope and resource constraints made it unattainable. This was the beginning of two separate approaches to implement PHC: selective and comprehensive.

The term PHC is now used in reference to both selective and comprehensive PHC approaches. A review of the literature highlights a contested position about the essential differences between the two approaches. The significance of this debate is important to note because the underlying values of SPHC and CPHC are different, which will determine the nature and outcomes of services.

SPHC service delivery is defined in the literature as providing medical interventions aimed at improving the health status of the most individuals at the lowest cost. Literature that describes SPHC states that the discourse assumes medical care alone creates health and ensures that control over health is maintained by health professionals. Researchers highlight that the health paradigm that sits behind SPHC is the traditional biomedical paradigm. The biomedical paradigm defines health as the absence of disease and illness and is concerned with improvements in physiological and psychological disease states via medical intervention and management. SPHC therefore focuses on reducing rates of specific diseases. Researchers note that although disease-specific interventions are recognised as important, SPHC and the resulting programs fail to fulfil the ideals of the Declaration of Alma-Ata, including the emphasis on self-reliance which is essential for communities to promote and sustain their health.

Alternatively, CPHC service delivery is defined in the literature as having an emphasis on social justice, equity, community control and working for social change that positively impacts on health and well-being. Literature that describes CPHC highlights that the emphasis is on addressing the conditions that generate
health and ill-health.\textsuperscript{11, 28, 31, 33, 37} Therefore provision of medical care is just one aspect of CPHC. Researchers note that the health paradigm that sits behind a CPHC approach is holistic, ecological and salutogenic. A holistic, ecological and salutogenic health paradigm is concerned with addressing inequities and developing a healthy functional ecosystem which supports the health and well-being of people and vice versa.\textsuperscript{12, 13, 38} It considers the complex interrelationships between social, economic, cultural, political and physical environmental determinants that impact on people’s health and wellbeing at individual, community and population levels.\textsuperscript{12, 13, 38} Researchers conclude that CPHC is based on community-oriented health promotion, prevention and curative services. The need for health services to employ a range of multi-sectoral activities and to work collaboratively with authentic community involvement is emphasised in the literature.\textsuperscript{11, 15, 25, 33, 36, 37, 39} Table 2 presents the key differences between SPHC and CPHC.\textsuperscript{15-19, 25, 28, 29, 33, 38, 40}

<table>
<thead>
<tr>
<th>Elements</th>
<th>Comprehensive PHC</th>
<th>Selective PHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health paradigm</td>
<td>Holistic, ecological and salutogenic</td>
<td>Biomedical</td>
</tr>
<tr>
<td>View of health</td>
<td>Positive wellbeing</td>
<td>Absence of disease</td>
</tr>
<tr>
<td>Locus of control over health</td>
<td>Communities and individuals</td>
<td>Health professionals</td>
</tr>
<tr>
<td>Major focus</td>
<td>Health through social justice, equity and community empowerment</td>
<td>Medical solutions for disease eradication</td>
</tr>
<tr>
<td>Health care providers</td>
<td>Multi-disciplinary teams</td>
<td>Medical doctors</td>
</tr>
<tr>
<td>Strategies for health</td>
<td>Multi-sectoral collaboration</td>
<td>Medical interventions</td>
</tr>
</tbody>
</table>

Some global health analysts argue that CPHC was an experiment that failed; others contend it was never truly tested.\textsuperscript{8, 11, 15, 17, 18, 23, 25} With only one year between the Declaration of Alma-Ata and the shift towards SPHC approach, the transformative potential of CPHC has remained largely unexplored by most countries. CPHC reform in many countries has involved more refinements and rhetoric than substantive changes.\textsuperscript{41} Lack of conceptual clarity, insufficient learning from other relevant disciplines and inadequate consideration of the realities within which diverse organisations actually operate have conspired to limit the application of CPHC in practice.\textsuperscript{11, 15, 17, 18, 28, 30, 31, 37}
CPHC aligns with the original intentions of PHC as it was first defined in the *Declaration of Alma-Ata*. However, for thirty years SPHC has remained the dominant health care approach underpinning funding opportunities, programs and services. As such, health services currently focus disproportionately on a narrow offer of specialised curative care and deliver fragmented services aimed at short-term disease control. Health services contribute little to equity and social justice and fail to get the best health outcomes for their investment. 

### 2.1.2 Renewed interest in Comprehensive Primary Health Care

In spite of the difficulty implementing CPHC to date, several public health researchers still highlight the potential for it to tackle current, worldwide challenges which are increasingly related to social, political and environmental structures and barriers. This continued interest in delivering CPHC services is consistent with the ‘New Public Health’ movement.

The New Public Health movement evolved from the ongoing dissatisfaction with the reductionist approach of medicine that SPHC employs. The dissatisfaction with SPHC has come about because there is no longer a single predisposing cause for disease, but a diverse range of associated determinants with behavioural, social, political and environmental bases. This shift in understanding about the causes of morbidity and mortality called for a new orientation to the analysis, management and prevention of priority health issues.

The New Public Health movement recognised: the broad nature of health promotion and the practical role it could play to support the reorientation of health services to CPHC; the need to work in collaboration with government and non-government agencies to affect change; the need for a partnership relationship with communities to increase community control over issues affecting health; and to ‘de-medicalise’ the control of health care.
The New Public Health movement found expression in several WHO initiatives and policy directions relevant to reorienting health services to be more health promoting, which is consistent with CPHC. Table 3 presents, in chronological order, WHO initiatives and policy directions relevant to the New Public Health movement that align with CPHC. 1, 2, 4-8, 47, 48
Table 3: WHO initiatives and policy directions relevant to the New Public Health movement

<table>
<thead>
<tr>
<th>WHO initiative or policy</th>
<th>Year</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Declaration of Alma-Ata</td>
<td>1978</td>
<td>Described vision of Primary Health Care that integrated public health, population and environmental concerns.</td>
</tr>
<tr>
<td>The ‘Health for All by the year 2000’ strategy</td>
<td>1981</td>
<td>Emphasised equity, public participation, intersectoral collaboration, and the need to reorient health systems and services.</td>
</tr>
</tbody>
</table>
| Ottawa Charter for Health Promotion                           | 1986 | Focused on supportive environments and healthy public policy. Five action areas included: Reorienting Health Services; Building Supportive Environments; Creating Health Public Policy; Strengthening Community Action; and Developing Personal Skills. Also set five priorities for health promotion in the twenty-first century:  
  • Promote social responsibility for health;  
  • Increase investments for health development;  
  • Consolidate and expand partnerships for health;  
  • Increase community capacity and empower the individual; and  
  • Secure infrastructure for health promotion (that includes a commitment to organisational development for settings for health promotion). |
| Jakarta Declaration on Leading Health Promotion into the 21st Century | 1997 | Supported need to address social determinants of health through the five action areas of the Ottawa Charter for Health Promotion.   |
| Renewal of the Commitment to Health for All and Primary Health Care | 1998 | After third evaluation of PHC uptake demonstrated limited uptake in industrialised countries, the World Health Assembly in 1998 renewed support for the ’Health for All’ position and documented Health for All in the 21st Century. Called for countries and health services around the world to seriously renew their commitment to PHC and their concern for social justice and reducing health inequities. |
| Alma-Ata: twenty-fifth anniversary International Report on Primary Health Care | 2003 | Called for countries and health services around the world to: ensure development of primary health care is adequately resourced to contribute to the reduction of health inequalities; strengthen human resource capability for primary health care to tackle the rising burdens of health conditions; support the active involvement of local communities and voluntary groups in primary health care; and support research to identify effective methods for monitoring and strengthening primary health care and linking it to overall improvement of the health system. |
| Closing the gap in a generation: health equity through action on the social determinants of health | 2008 | Responded to increasing concern about these persisting and widening inequities, WHO established the Commission on Social Determinants of Health (CSDH) in 2005 to provide advice on how to reduce them. The Commission’s final report was launched in August 2008, and contained three overarching recommendations:  
  • Improve daily living conditions;  
  • Tackle the inequitable distribution of power, money and resources; and  
  • Measure and understand the problem and assess the impact of action. |
| World Health Report: Primary Health Care (Now More Than Ever) | 2008 | Health systems need to respond better and faster to the challenges of a changing world; acknowledged PHC can do that.                 |
| Adelaide Statement on Health in All Policies moving towards a shared governance for health and wellbeing | 2010 | Emphasised that government objectives are best achieved when all sectors include health and wellbeing as a key component of policy development. Acknowledged that causes of health and wellbeing lie outside the health sector and are socially and economically formed. |
2.1.3 Current state of Primary Health Care reform

Findings presented in the WHO’s 2008 World Health Report, *Primary Health Care: Now More Than Ever*, demonstrated that health systems with strong PHC foundations are more efficient, have lower hospitalisation rates, fewer health inequalities and better health outcomes including lower mortality than those that do not.\(^{50-52}\) The report found that when countries at the same level of economic development were compared, those organised around the tenets of CPHC produced a higher level of health for the same investment.\(^{32}\)

As this type of supportive evidence for CPHC grows, there is increasing recognition for its value nationally and internationally. Governments are starting to realise that strengthening and improving the way in which CPHC is provided is vital in determining how well the health system responds to current and emerging health issues.\(^{53}\) Many industrialised countries including New Zealand, the United Kingdom and Canada have made significant investment in reform processes directed at strengthening the Primary Health Care sector.\(^{54-56}\) These reform processes encourage a population-health focus, the greater use of multi-disciplinary teams, increased accountability for performance and improved access to services.\(^{54-56}\)

2.1.3.1 Primary Health Care reform in Australia

Like other industrialised countries, Australia’s health care system faces significant challenges due to the growing burden of chronic disease, an ageing population, workforce pressures, and unacceptable inequities in health outcomes and access to services.\(^{57}\) Compounding these challenges, PHC in Australia operates as a disparate set of services rather than an integrated service system.\(^{9, 11, 28}\) It has therefore been difficult for health services to respond effectively to changing circumstances such as, demographics, the burden of disease, emerging technologies and clinical practice.\(^{22, 57-59}\)

In 2007 the Australian Government responded to these challenges and made PHC reform a policy priority. It commissioned three reviews into Australia’s health care
system and undertook consultation with key stakeholders. During 2009 and 2010 the Australian Government released several strategic policy documents based on findings. Policy directions relate to three key areas of national reform: 1) National Health and Hospitals Network; 2) *National Primary Health Care Strategy*; and 3) National Preventative Health Taskforce. Policy directions are presented under the three key reform areas in Table 4. 53, 57, 60

The *National Primary Health Care Strategy* is Australia’s first comprehensive national policy statement and strategy for PHC. It is a broad view of what CPHC will look like in Australia 53. The strategy refers to five key building blocks:

1. Regional integration;
2. Information and technology, including eHealth;
3. Skilled workforce;
4. Infrastructure; and
5. Financing and system performance.

Drawing from the five key building blocks, four key priority areas for change have been identified:

1. Improving access and reducing inequity;
2. Better management of chronic conditions;
3. Increasing the focus on prevention; and
4. Improving quality, safety, performance and accountability.

For each building block and priority area, key reform initiatives have been developed. One of the key reform initiatives is the development of Primary Health Care Organisations (PHCOs); named Medicare Locals by the Australian Government. The aim of PHCOs is to provide CPHC to local communities. PHCOs will evolve from the current Divisions of General Practice Network and will be implemented in July 2011.
Table 4: Three key areas of Australia’s PHC reform and related documents

<table>
<thead>
<tr>
<th>National Health and Hospitals Network</th>
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<tbody>
<tr>
<td><strong>Related documents</strong></td>
<td><strong>Content</strong></td>
</tr>
<tr>
<td>A National Health and Hospitals Network: Delivering the Reforms (July 2010)⁶⁰</td>
<td>Provides outline of implementation process for the delivery of the National Health and Hospitals Network reforms. Includes high-level implementation roadmaps, major milestones and timelines</td>
</tr>
<tr>
<td>A National Health and Hospitals Network: Delivering Better Health and Better Hospitals (May 2010)⁶¹</td>
<td>Detail regarding the National Health and Hospitals Network and its establishment. Provides detail on introduction of PHC Organisations and other infrastructure funding for general practice</td>
</tr>
<tr>
<td>A National Health and Hospitals Network: Further Investments in Australia’s Health (April 2010)⁶²</td>
<td>Includes major funding investments across hospitals, general practice and PHC, workforce and aged care</td>
</tr>
<tr>
<td>A National Health and Hospitals Network for Australia’s Future (March 2010)⁶³</td>
<td>Outlines stage one of the Federal Government’s National Health Reform Plan and key policy features of structural reform of health system</td>
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<table>
<thead>
<tr>
<th>National Primary Health Care Strategy</th>
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<tbody>
<tr>
<td><strong>Related documents</strong></td>
<td><strong>Content</strong></td>
</tr>
<tr>
<td>Building a 21st Century Primary Health Care System: Australia’s First National Primary Health Care Strategy (May 2010)⁵⁷</td>
<td>Provides road map to guide current and future policy and practice in Australian PHC sector. Identifies five key building blocks to underpin PHC system</td>
</tr>
<tr>
<td>Primary Health Care Reform in Australia: Report to Support Australia’s First National Primary Health Care Strategy (May 2010)⁵³</td>
<td>Provides an analysis of issues on which strategy is based</td>
</tr>
<tr>
<td>Building a 21st Century Primary Health Care System: A draft of Australia’s First National Primary Health Care Strategy (August 2009)⁶⁴</td>
<td>Draft strategy provides a draft road map for future policy and practice in PHC</td>
</tr>
<tr>
<td>Towards a National Primary Health Care Strategy: A discussion paper from the Australian Government (October 2008)⁵⁶</td>
<td>Discussion paper provides broad framework and basic information on key issues impacting PHC. Purpose: stimulate input and comment to assist in the development of strategy</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>National Preventative Health Taskforce</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Related documents</strong></td>
<td><strong>Content</strong></td>
</tr>
<tr>
<td>Taking Preventative Action (May 2010)⁵⁹</td>
<td>Federal Government response to final report from the National Preventative Health Taskforce</td>
</tr>
<tr>
<td>Australia: the Healthiest Country by 2020 - National Preventative Health Strategy (June 2009)⁵⁵</td>
<td>Final report from the National Preventative Health Taskforce, proposes range of strategies to address health issues</td>
</tr>
<tr>
<td>Australia: the Healthiest Country by 2020 (October 2008)⁵¹</td>
<td>Discussion paper outlines targets suggested by National Preventative Health Taskforce with relation to obesity, smoking, alcohol consumption and Closing the Gap measures</td>
</tr>
</tbody>
</table>

In response to the announcement that Divisions of General Practice will become PHCOs, the Australian General Practice Network (AGPN) produced *A Blueprint for improving the health and wellbeing of the Australian population – the role and function of Primary Health Care Organisations.*⁵² The blueprint outlines six key roles of the PHCOs:

1. **Undertake population health and service planning;**
2. **Offer access to comprehensive services to improve, maintain and restore people’s health by strengthening the effectiveness, efficiency and vitality of regional PHC services, including an increased emphasis on health promotion and illness prevention;**
3. **Identify and tackle health inequalities by ensuring access to PHC services that meet community need, particularly where there are service gaps;**
4. Coordinate care across PHC providers and between primary and secondary/tertiary levels of care by promoting cooperation, collaboration and communication with other regional organisations with an interest in health. Relationships with the acute care sector could include improved vertical integration ranging through to the delivery of specific services designed to reduce demand and cost pressures such as hospital avoidance programs, to models of care designed to promote coordination such as shared care arrangements;
5. Develop and support the PHC workforce, particularly in areas of acute workforce shortage (eg. rural and remote areas); and
6. Continuously improve the quality of services and programs by effective use of good data and eHealth systems.

Significant organisational and infrastructure development will be required to redefine Divisions of General Practice’s core business from its traditional SPHC focus to CPHC service provision. Given health services, around the world, have historically struggled with reorientation and the application of CPHC into organisational practices, it is critical that Divisions understand the task at hand. Divisions of General Practice need effective leadership and adequate resources to operationalise CPHC into the new PHCO structures. Access to information that provides clear steps on how a health service can plan, implement and evaluate a strategy to reorient from SPHC to CPHC is critical.22, 29, 53, 66

2.1.4 Health promotion as a strategy to reorient organisations to deliver CPHC
Health promotion is increasingly recognised as a useful discipline that can provide practical strategies for health services to reorient to CPHC.15, 17, 23, 24, 28, 34, 42, 67-69
Health promotion and CPHC align well because both work towards creating structural social change and equity.15 Public health researchers emphasise health promotion is a transformative practice that can achieve better health for all, when conducted from CPHC foundations.11, 12, 25, 70 Health promotion provides a set of complimentary change strategies which are outlined in the Ottawa Charter for Health Promotion.39

2.1.4.1 The Ottawa Charter for Health Promotion
The Ottawa Charter for Health Promotion was developed at the first International Conference on Health Promotion in Ottawa, Canada 198639 in response to an
ongoing need for health services to have practical strategies to achieve the goals of the Health for All by the Year 2000 initiative. The Ottawa Charter identifies three strategies for health promotion: advocate; enable; and mediate. It also articulates five action areas for health promotion priority: 1) Building healthy public policy; 2) Creating supportive environments; 3) Strengthening community actions; 4) Developing personal skills; and 5) Reorienting health services. The Charter’s three strategy areas and five action areas are presented in Table 5.

Table 5: Ottawa Charter for Health Promotion

<table>
<thead>
<tr>
<th>Ottawa Charter for Health Promotion</th>
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<tbody>
<tr>
<td><strong>Three strategies for health promotion</strong></td>
</tr>
<tr>
<td>Advocate: Good health is a major resource for social, economic and personal development, and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour or harm health. Health promotion aims to make these conditions favourable, through advocacy for health.</td>
</tr>
<tr>
<td>Enable: Health promotion focuses on achieving equity in health. It aims to reduce differences in current health status and ensure the availability of equal opportunities and resources to enable all people to achieve their full health potential. This includes a secure foundation in a supportive environment, access to information, life skills and opportunities to make healthy choices. People cannot achieve their fullest health potential unless they are able to control those things that determine their health. This must apply equally to women and men.</td>
</tr>
<tr>
<td>Mediate: The prerequisites and prospects for health cannot be ensured by the health sector alone. Health promotion demands coordinated action by all concerned, including governments, health and other social and economic sectors, non-government and voluntary organisations, local authorities, industry and the media.</td>
</tr>
<tr>
<td><strong>Five action areas for health promotion priority</strong></td>
</tr>
<tr>
<td>Build healthy public policy: Health promotion policy combines diverse but complementary approaches, including legislation, fiscal measures, taxation and organisation change. Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors and the development of ways to remove them.</td>
</tr>
<tr>
<td>Create supportive environments - the protection of the natural and built environments and the conservation of natural resources must be addressed in any health promotion strategy.</td>
</tr>
<tr>
<td>Strengthen community actions: Community development draws on existing human and material resources to enhance self-help and social support, and to develop flexible systems for strengthening public participation in, and direction of, health matters. This requires full and continuous access to information and learning opportunities for health, as well as funding support.</td>
</tr>
<tr>
<td>Develop personal skills: Enabling people to learn (throughout life) to prepare themselves for all of its stages and to cope with chronic illness and injuries is essential. This has to be facilitated in school, home, work and community settings.</td>
</tr>
<tr>
<td>Reorient health services: The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Reorienting health services also requires stronger attention to health research, as well as changes in professional education and training.</td>
</tr>
</tbody>
</table>

Through its three strategy and five action areas the Charter offers multi-level practical actions that health services can use to translate CPHC philosophy into everyday practice. PHC values and the Charter’s action areas to achieve CPHC practice are illustrated in Figure 1.
One of the five action areas emphasised in the Charter is the reorientation of health services. Reorientation is fundamentally about using a new set of values to change an organisation's culture to be more health promoting. In reorienting health services, the Charter states the role of the health sector must move increasingly in a health promoting direction, beyond its responsibility for providing clinical and curative services. It states that health services need to embrace an expanded mandate that supports the needs of individuals and communities for a healthier life and open channels between the health sector and broader social, political, economic and physical environmental components:

Reorientation of health services is more than reallocating health dollars towards community-based health services to be responsible for ‘doing’ more health promotion; it is challenging health services (including hospitals) to change to work interdependently to improve the health of the people who access their services as well as the broader community they serve. It is important to be clear that reorientation is not about project management of health promotion projects in health services, rather an approach to organisational development and change.’

Since the Ottawa Charter, several health services have committed to the Charter’s reorientation strategy and implemented organisational change processes. This has led to a considerable increase in research over the past ten years into what health services need to change to build health promotion capacity.
This section of the literature review has described the evolution of PHC and the ongoing challenges with its implementation. It has detailed the current state of PHC reform in Australia and policy directions that will transition Divisions of General Practice into PHCOs. Health promotion as a discipline and the Ottawa Charter three strategy and five action areas were presented as ways in which health services can build organisational capacity to reorient services to deliver CPHC. The next section describes reorientation frameworks that have been developed to increase organisational capacity to be more health promoting.

2.2 Health service reorientation

2.2.1 Health service reorientation frameworks

The strategies and action areas of the Ottawa Charter for Health Promotion have been suggested as useful to reorient the leadership, strategic direction, structures, policies and practices of a health service and its staff to be more health promoting and to deliver CPHC. This section of the literature review critiques existing health service reorientation frameworks and case examples including: organisational capacity building; organisational change; and organisational development.

2.2.1.2 Organisational capacity building strategies

New South Wales (NSW) Health has been instrumental in developing a case around the importance of building health promotion capacity in health and related sectors. Guidance and direction for organisations wanting to build health promotion capacity has been provided in two key documents: 1) Indicators to Help with Health Promotion Capacity Building; and 2) A Framework for Building Capacity to Improve Health. Capacity building is defined in these documents as an approach to the development of sustainable skills, organisational structures, resources and commitment to health improvement in health and other sectors, to prolong and multiply health gains many times over. It is emphasised that capacity building occurs both within programs and more broadly within systems and leads to greater
capacity of people, organisations and communities to promote health. It is acknowledged that capacity building activity may be developed with individuals, groups, teams, organisations, inter-organisational coalitions or communities.\textsuperscript{73, 85}

*An Framework for Building Capacity to Improve Health* describes five key action areas that organisations can use to build health promotion capacity (Figure 2).\textsuperscript{73} These include: 1) Workforce development; 2) Organisational development; 3) Resource allocation; 4) Leadership; 5) Partnerships.

![NSW Health Capacity Building Framework](image)

Figure 2: NSW Health Capacity Building Framework

While several organisations have applied this framework to increase organisational capacity to deliver effective health promotion, few projects have been evaluated.\textsuperscript{42, 68, 71, 80, 82, 86} One evaluation study conducted by Heward *et al.* in 2007 examined the impact of three case studies that applied components of the NSW Health Capacity Building Framework.\textsuperscript{26}

The first case study invested significant resources into building collaborative partnerships to improve the capacity of the primary and community health sector to plan, implement and evaluate health promotion, with a focus on integration and
partnerships. While some positive change was reported across four key capacity building areas (organisational structures; readiness for partnerships; leading and validating the role of health promotion; and workforce development), barriers were also identified. Key barriers that inhibited desired impact of the strategy related to: communication within all layers of the system; active commitment and involvement of managers; having a clear and consistent vision across all levels of the organisation; and having adequate resourcing for practice and internal change.\textsuperscript{25} These barriers concur with organisational change theory which highlights that if a consistent vision of change across all levels of the organisation does not exist, change is unlikely to occur.\textsuperscript{25, 26, 87}

The aim of the second case study was to improve health promotion service plans written by staff from multidisciplinary backgrounds through the use of a planning tool. Results from the study showed that staff did not respond to the planning tool because the work plan did not reflect upon the readiness of the staff and the organisational cultural context for change. Management fell into the trap of not sufficiently managing the organisational culture or recognising some of the less viable aspects of the culture that were not ready for change. This finding also aligns with organisational change theory which states the articulation of a vision for the desired future is essential to implement sustainable change.\textsuperscript{79}

The third case study assessed the impact of a five day short course in health promotion for approximately 800 participants between 2001 and 2004. Evaluation results showed the course built participants’ knowledge and skills and improved their capacity to understand the language of health promotion. However, participants identified barriers to implement their knowledge in the workplace after completing the course. A common viewpoint was the need for more management support with an emphasis on systems that support workers to practise health promotion.\textsuperscript{80} This result emphasises a key point in organisational change theory that states supportive infrastructure must be in place to enable staff to perform their duties.\textsuperscript{88}
Including organisational change theory as a distinct element in capacity building strategies is a common finding across all three case studies. These evaluation results therefore illustrate the need to expand reorientation processes to include organisational change. While organisational change is a component in the framework, Heward et al.\textsuperscript{26} propose that it is insufficiently explored as an element in its own right. They state organisational change should be applied more purposefully to capacity building frameworks if health promotion is to be strengthened and sustained.\textsuperscript{26}

### 2.2.1.3 Organisational change strategies

While capacity-building strategies to reorient health services addresses some of what organisations need to do to be more health promoting, some components of organisational change cannot be pre-determined and need to be shaped given the contextual features of the organisation or system. Organisational change needs to be built into reorientation strategies to ensure it is acknowledged as a crucial component for effectiveness and sustainability.\textsuperscript{26} ‘Settings’ for health promotion is an approach that WHO initiated as a way of including organisational change into capacity building frameworks.\textsuperscript{25, 44} The ‘settings’ approach was introduced to ensure organisation’s core business was supportive of health promoting environments.

#### 2.2.1.3.1 Settings for health promotion

‘Settings’ for health promotion was one of the ‘Health for All’ policy targets for the WHO, whereby the goal was that all settings of social life and activity such as city, school, workplace, neighbourhood and home should provide greater opportunities for promoting health by the year 2000.\textsuperscript{36} ‘Settings’ are described as the place or social context where people engage in daily activities in which environmental, organisational and personal factors interact to affect health and wellbeing.\textsuperscript{36} The goal of a settings-based approach is to create a supportive environment for health.
The Ottawa Charter for Health Promotion furthered the ‘settings’ agenda, and made reorientation of health services an explicit action area of the Charter.\textsuperscript{39}

The settings approach was a strategic way to move the health promotion focus away from individual behaviours and communities at risk to developing a strategy that encompasses a total population within a given setting. Healthy Cities, Health Promoting Schools, Health Promoting Hospitals and Health Promoting Workplaces (also known as health promoting enterprises and healthy organisations) conceptualised the settings approach and positioned organisational change within reorientation frameworks.\textsuperscript{89} The Women’s and Children’s Hospital in South Australia made a commitment to become a Health Promoting Hospital in 1993 as part of its strategic planning process of amalgamating two hospitals.\textsuperscript{90} There were two areas of health promotion development: 1) a health promotion program; and 2) health promotion activity that could be undertaken by the hospital.

The health promotion program focused on developing the infrastructure to support health promotion and organisational change to reorient the health service. Without the development of the program it was argued that health promotion activity would not be effective or sustainable.\textsuperscript{91} The program incorporated the following key elements: strong leadership at different levels within the organisation; health promotion statements in the hospital’s vision, policies and procedures; health promotion evaluation plans; workforce development; and human, physical and financial resources.

The area of health promotion activity that could be undertaken by the hospital focused on five health promotion categories. Categories included: 1) patient and family with a focus on individuals and groups; 2) staff that were linked to workplace health promotion; 3) organisational wide policies to develop the organisation to be more health promoting; 4) physical environment including built and environmental practices; and 5) community including population health strategies.\textsuperscript{91}
In addition to building on the notion of two areas of health promotion development, a description of a health promoting hospital was developed that identified action at organisational and practice levels (p51)\(^9\) (Table 6).

Table 6: Description of requirements for organisational and practice level commitment

<table>
<thead>
<tr>
<th>Organisational level</th>
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<tbody>
<tr>
<td>• Establish an organisational health promotion program. This includes health promotion being incorporated into the hospital's vision and strategies direction statements. This program should be supported by strong leadership by the Board and CEO, and by providing health promotion leadership within the organisation, and educating and supporting staff to enable them to integrate the principles of health promotion into their practice</td>
</tr>
<tr>
<td>• Ensure resources are allocated (human, facilities and financial) to support the organisational program</td>
</tr>
<tr>
<td>• Ensure that the hospital identifies the population health issues and the determinants of health and ill-health by using the results of the research, relevant other data, state and national policies and public and staff concerns</td>
</tr>
<tr>
<td>• Ensure attempts to reduce health inequities for specific groups are reflected in organisational decisions</td>
</tr>
<tr>
<td>• Ensure the hospital allocates resources to facilitate the shift from the biomedical paradigm of health care, to provide care and services based on a Primary Health Care philosophy that is more consistent with the 'New Public Health' paradigm</td>
</tr>
<tr>
<td>• Ensure an organisation-wide strategy is in place to facilitate and support community and consumer participation at the health service and practice levels</td>
</tr>
<tr>
<td>• Ensure the organisation is structured and managed in a way that supports collaborative relationships with other stakeholders to address health issues in the broader community</td>
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<thead>
<tr>
<th>Practice level</th>
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<tr>
<td>• Ensure health promotion is integrated into the working role and responsibilities of staff</td>
</tr>
<tr>
<td>• Ensure the results of the analysis of population health issues and the determinants of health and ill-health are used when planning and implementing health promotion activities and approaches to service delivery</td>
</tr>
<tr>
<td>• Ensure health inequities for specific groups are considered and addressed when planning and implementing health promotion activities and approaches to service delivery</td>
</tr>
<tr>
<td>• Ensure advocacy against the predisposing conditions to ill-health/injury</td>
</tr>
<tr>
<td>• Work to a level of partnership with patients and their families, and community organisations/groups in the provision of care and service delivery</td>
</tr>
<tr>
<td>• Facilitate effective learning by providing appropriate health information to patients and their families and the wider community, and utilise effective educational resources and mass media</td>
</tr>
<tr>
<td>• Collaborate with others (intra and inter-sectoral) in the planning, implementation and evaluation of health promotion activities</td>
</tr>
<tr>
<td>• Use a diverse combination of health promotion strategies to affect change, such as lobbying for legislation and policy change, facilitating organisational change, encouraging community action and providing education to create more supportive environments for health and improved health status</td>
</tr>
<tr>
<td>• Implement health promotion activities in practice for the five areas of patient, family, staff, organisational, physical environment and community</td>
</tr>
<tr>
<td>• Ensure that health promotion actions are evaluated and the results used to inform practice and support necessary changes in the setting and community</td>
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The work around health promotion settings has contributed significantly to the understanding of what health services need to change internally to be more health promoting.\(^8\) However, value of the settings approach began to be debated in the late 1990s due to its inward organisational change focus. Public health researchers noted that the settings approach encouraged services to see themselves as individual settings rather than a broad sector of integrated services.\(^1, 25, 28, 31\) More
recently, the generic term of ‘health services’ has been proposed as a way of broadening the inward focus to unify all health services in their commitment to improve individual and population health outcomes through health promotion.\textsuperscript{25}

2.2.1.3.2 Health promoting health services

Johnson and Paton stress that the focusing on health promoting services is necessary to more effectively address population health inequities.\textsuperscript{25} They state the term ‘health services’ is preferable to a focus on specific health settings, such as hospital, community health service, palliative care, General Practice, etc., because it has more potential to reduce compartmentalisation of responsibility for the health of the community and prevent ad hoc and uncoordinated health promotion action.\textsuperscript{25}

Johnson and Paton describe the purpose of a health promoting health service is to:

\begin{quote}
Reorient the organisational infrastructure and the practice of staff to be more health promoting through creating a better balance of: clinical care and rehabilitation; prevention and health promotion (p64)\textsuperscript{25}.
\end{quote}

They also developed a detailed definition based on the basic premise that any health-promoting health service needs to apply the philosophy of CPHC and the strategies of the Ottawa Charter for Health Promotion in order to reorient organisational practices to be more health promoting. A comprehensive definition of a health promotion health service is presented in Table 7 (p64).\textsuperscript{25}
Table 7: Comprehensive definition of a health promoting health service

<table>
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<tr>
<th>Health promoting health services make a long-term commitment to reorient leadership, strategic directions, structures, policies and management and clinical practices to incorporate:</th>
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<tbody>
<tr>
<td>• An explicit valuing of 'health' in its broadest context</td>
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<tr>
<td>• An application of the broader socio-environmental determinants of health to analysing health problems and planning interventions</td>
</tr>
<tr>
<td>• An application of the Primary Health Care philosophy to the way the health service works (for example, integration of health services, reducing inequities, community/consumer participation, responsiveness to local needs, empowerment and development of self-reliance at individual and community levels, and multidisciplinary and multi-sectoral action)</td>
</tr>
<tr>
<td>• An application of the five action areas of the Ottawa Charter for Health Promotion and the approaches of advocating, enabling and mediating to make a positive and equitable impact on the health of individuals and the broader community</td>
</tr>
<tr>
<td>• A balanced approach to disease and injury management and rehabilitation, prevention and health promotion; not only for individual patients and families but also for the community served by the health service</td>
</tr>
<tr>
<td>• An integration of health promotion into the practice of staff to reorient their roles to achieve health gains for individuals and the broader community</td>
</tr>
<tr>
<td>• Community and consumer participation in decision-making at the individual care and health service levels, and</td>
</tr>
<tr>
<td>• Collaboration with others (multidisciplinary, intrasectorally and intersectorally) to improve the health status of the community it serves, and the status of the physical environment, while continuing its organisational commitment as a setting to improve the health and wellbeing of patients and their families and staff.</td>
</tr>
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Only one example of an applied health-promoting health services’ framework that has been evaluated was found in the literature. It was developed by the Health Education Board of Scotland for use by National Health Services (NHSs) as a guide to good practice. The NHSs Health Promoting Health Services Framework aimed to ensure health promotion was an integral and sustainable part of health care, service delivery and organisational development across a range of services. It was recognised that while the primary duty of health services is to provide services for patients and clients, they also have a responsibility to maintain and improve the health of their communities and employees. The framework objectives, principles and structure are presented in Table 8.
The evaluation of the NHS framework found that it had limited impact. According to Martin, the evaluation results suggest that while the framework focused on health promotion practice in health services, it was limited in impact if there was no infrastructure in health services to support those efforts. The infrastructure that Martin refers to is: effective leadership; coordination of health promotion activity; training support within the project and the wider organisation; and affirmation by senior management. This supports the previous work of Johnson and Parsons who argued the work of health promotion settings is as much about developing the infrastructure of a health service to support health promotion and organisational change, as it is about health promotion practice and activity.

Johnson and Paton claim that previous reorientation models clarify key concepts about what things a health service needs to change but are of limited use when not placed in the context of how to develop organisational infrastructure to support the
desired change. They propose the need for a stronger focus on developing the organisation to strengthen the support for health promotion and its impact.25

2.2.1.4 Organisational development strategies

In recent years, organisational development (OD) has emerged as a way of helping organisations improve by better managing the changes they need to make.11, 95-98 There is currently no universal definition of the term ‘organisational development’. In the literature, the term is used by some authors to represent any program of development within an organisation that is designed to meet either organisational or personal objectives. Others use the term to refer only to comprehensive, organisation-wide development programs that embrace common principles and approaches based on knowledge gained from applied behavioural science.96-99

The WHO supports the definitions that refer to the comprehensive, organisation-wide development programs and have identified this as the preferred approach to change management for reorienting health services to be more health promoting.44, 89 A comprehensive view of OD are reflected in the following definitions:

Organisational development is the application of behavioural science action research and systems theory to human systems, to increase the internal and external effectiveness of the organisation, especially in managing change, using participative processes that involve all those affected (p19).100

Organisational development is an effort 1) planned, 2) organisation wide, and 3) managed from the top, to 4) increase organisational effectiveness and health through to 5) planned interventions in the organisation’s process using behavioural-science knowledge (p9).101

Organisational development is a set of behavioural science-based theories, values, strategies and techniques aimed at the planned change of the organisation work setting for the purpose of enhancing individual development and improving organisational performance, through the alteration of organisational members’ on-the-job behaviours (p272).98

Johnson and Paton25 state that comprehensive OD is a particular type of change management that uses distinctive approaches, assumptions and values. They identify a set of defining characteristics and features of a comprehensive OD approach. These include:
• OD applies behavioural science to bring about the planned change and development in organisations, and emphasises that it is possible to bring about changes through a systematic process;
• The target of change is the organisation or system: OD has an organisation rather than an individual staff member focus;
• The goals of OD are increased organisational effectiveness and individual development;
• OD employs an open systems perspective or systems thinking. Systems thinking views the organisation as an arrangement of interrelated and interdependent elements that have collective interaction to form an entity that is a system;
• OD emphasises the importance of data-gathering and diagnosis of an organisation situation (consistent with the development of evidence-based practice in health care); and
• OD is a value-driven approach that stresses the importance of key values, principles and ethical standards in developing and changing organisations.

Johnson and Paton\textsuperscript{25} propose that the OD approach to managed change is appropriate for the creation of health promotion health services in three key ways:
1. The OD emphasise on the importance of diagnosis of organisations situations fits with evidence-based values and practices in health care;
2. The OD emphasise on systems thinking and approaches is suitable for the complexity of health care organisations; and
3. The OD tradition of involvement and participation of people in change fits with health promoting values.

A search of the literature found no studies that have evaluated the implementation of OD to reorient a health service to be more health promoting. While OD is widely used by industry, its use in health services is less evident. Johnson’s framework, titled \textit{Health Promoting Health Services Reorientation Framework} is the most recent example of a framework that acknowledges the importance of OD in the
reorientation of health services. The framework is used as a basis to present a new way of conceptualising reorientation and is said to be particularly useful for planning and evaluating the reorientation of a health service to become more health promoting. The framework is based on the author’s experience in reorienting health services. The components of the framework are evidence-based however it has not been evaluated. At this point in time, the framework is the most comprehensive reorientation tool available to guide the reorientation of a health service.

2.2.1.4.1 The Health Promoting Health Services Reorientation Framework
The Health Promoting Health Services Reorientation Framework (HPHSRF) is outlined in Figure 3 and consists of the following five components:

- Reorientation goal;
- Foundation approaches;
- Organisational health promotion program;
- Health promotion sub-program categories; and
- A health promotion approach.

Although these components are inter-related they are described separately. Johnson stresses that the first three components are the most influential in an organisational reorientation process that supports sustainable organisational change. It is these three components that differ from the focus of previous reorientation strategies described above. The components are about establishing the reorientation goal; basing change on an established values base of CPHC and an OD approach to change; and identifying two different levels of change and related change performance areas.
2.2.1.4.1.1 Reorientation goal

Of significance to the reorientation process is the need to clarify the reorientation goal at the outset, and determine whether the health service is serious about reorientation. Johnson and Paton recommend asking the following questions to determine organisational goals for health promotion. Does the organisation want to:

1. ‘Do’ a health promotion project?
2. Make health promotion the responsibility of a specific person, department, division or area of health service to do?
3. Become a health promotion setting where health promotion efforts are centred on improving the quality of services provided and the health of patients, staff and the physical environment of the health service?
4. *Become a health promoting setting and work with others to improve health outcomes for individuals who use the service and the health of the broader community? (p 72).*

If a health service wants to become more health promoting, but in practice its culture is one of reacting to crisis and short-term demands, the first two reorientation goals are said to be the reality. Being clear about this from the outset will ensure those leading the reorientation process will be aware where best to pitch the reorientation efforts in the short term. The third goal aligns with a settings approach which is about reorienting the internal systems and structures of an organisation. The fourth goal aligns with a high-performing organisation as defined by Skinner in his organisational prototypes. It also fits with the initial ‘Health for All’ goals for health services to promote the health of the communities they serve, including the health of individuals who enter the health service and those who do not.

Johnson and Paton suggest Goal 4 would be the most beneficial organisational reorientation goal for health services to achieve CPHC. This reorientation goal generally requires a health service to undergo transformational change to reorient not only the organisation, but also the practices of staff and the way the health service works with the community and other organisations and agencies.

2.2.1.4.1.2 Foundation approaches

Also of significance is that the approach to reorientation is underpinned by values based on a CPHC and OD approach to manage change. A ‘value-based’ approach to reorienting health services is proposed in the HPHSRF, whereby these two foundation approaches provide the explicit values to drive the change process and outcomes. They are about influencing the priorities of a health service and its way of working to reflect a CPHC philosophy, using OD as an approach to change.

*Primary Health Care approach to health*

As identified in earlier sections, integrating a CPHC philosophy is fundamental to the way a health-promoting health service should work. CPHC has not been well
articulated in many settings approaches to health promotion to date. The focus of the settings approach has been on the strategy and actions areas of the *Ottawa Charter for Health Promotion* and not necessarily inclusive of CPHC values. The framework clearly demonstrates the difference between the *Ottawa Charter* components and CPHC values and the need for both in health service reorientation. The key elements of a CPHC reorientation approach include:¹, 2, 15, 66, 70, 76, 91, 97, 102

- A broader understanding of health that encompasses a full appreciation of the broader determinants of health;
- Individual care and population health perspectives in analysing and addressing health issues;
- An emphasis on reducing inequities in health;
- A participatory approach (community and consumer);
- Encouraging and supporting self-help (individuals and communities);
- Being responsive to local health needs;
- Respecting diversity; and
- Collaboration and integration (multidisciplinary, intrasectoral and intersectoral).

These elements provide a focus for organisational systems change as well as the integration of health promotion action into CPHC practice. Johnson and Paton emphasise the need for health services to move beyond the rhetoric to challenge how to integrate a CPHC approach.²⁵

*Organisational development approach to change*

Another foundation approach used in the HPHSRF is OD. Johnson and Paton emphasise that the value of OD as an organisational change management theory, is that its assumptions and principles align with CPHC philosophy. The key elements of OD include the need to have:²⁵, 29, 95

- A clear purpose for the needed change;
• An understanding of how organisational change can be accomplished through a planned approach;
• An aligned mission, values and goals to support the desired changes;
• A long-term view and commitment to the change process;
• Need to have senior management commitment and support;
• Strong leadership at different levels of the organisation;
• The capacity to enable key stakeholders (including community groups, consumers, staff and other relevant services) to participate in the planning, and implementation of change processes;
• A plan for sustainability; and
• Planned evaluation and accountability processes.

The HPHSRF is unique as it emphasises challenges associated with changing health services and the need for effective change management theories. The use of the Paton-Johnson Model of Change Management\textsuperscript{25} which is based on OD theory is recommended for effective and sustained organisational change. This model emerged from discussion about how health change agents could bring about change in their host organisations to make them more health promoting. It is a practical tool that enables change agents to generate ideas about how to bring about required change (Figure 4).\textsuperscript{25} Paton and Johnson state the model is particularly relevant for three reasons:

1. \textit{It has been developed specifically for the context of health-promoting organisational change. The nature of organisational change in this context has specific features that must be accommodated in any planned approach to change. Health-promoting organisation change is almost a subversive activity because the change agents working to create more health-promoting organisations are frequently working from outside the entrenched power and ideology base of conventional approaches to health care.}

2. \textit{A values-based approach to change management is important in this field. When bringing about change in health care to create more health promoting health services, the change process and approaches employed must reflect the value bases of the type of organisation that is being created. There is something fundamentally flawed and hypocritical about trying to create health services that enhance health and wellbeing if the processes used to create the organisation do not reflect its organisational values. Thus, the methods of change management advocated emphasise values of participation, involvement and empowerment of people, systems thinking, honesty and openness and evidence-based approaches.}
3. There is still a need for practical guidance on how to bring about effective organisation change (p108).

Figure 4: Four sequential stages of change management

Paton and Johnson explain that effective change management involves a process that moves from a conversation stage of informal dialogue to more structured change planning. The initial stages of the change process are important for starting processes for developing a vision about what the organisation wants to move to. A diagnosis of the current situation is important to fully understand and answer the question of what happens now, before further development of the organisational vision.

Johnson and Paton recommend the use of Johnson’s Health Promoting Health Services: Organisational and Activities/Practice Assessment Tool (Appendix 1) in the diagnosis phase. The tool consists of two parts and has been designed using the HPHSRF as a basis. It assists health services to assess their status with regard to becoming a health promoting health service. It can be used to determine where a health service is situated in its commitment to becoming a health-promoting health service, and where it can prioritise and strategically plan for further development. It can also be used as an evaluation tool to reassess the health service at intervals to measure change performance. Part one of the tool assesses the Reorientation Goal and the Organisational Health Promotion Program. Part two of the tool assesses the Health Promotion Activity/Practice.
tool also assesses who the organisation is collaborating with, the types of health promotion strategies being used and what model of health promotion the organisation adopts\textsuperscript{25}.

An additional tool Johnson and Paton recommend for the diagnosis phase is Skinner and Botelho’s *Organisational Prototype* (Appendix 2).\textsuperscript{27} This tool is used to gain an overview of how people view their health service. It can be completed individually and collated to ascertain a group ‘picture’ of the health service.

The plan for change of the Paton-Johnson Model for Change Management includes multiple activities aimed at bringing about the desired vision. Resistance to change and gaining commitment for change are critical and must be planned for and managed. Implementing change involves an organisational culture change program. It also needs to include techno-structure change; the development of people, and continuous monitoring and re-diagnosis to check the impact of activities.\textsuperscript{25}

### 2.2.1.4.1.3 Organisational health promotion program

Johnson and Paton state that for health service reorientation to become more sustainable and effective, it is essential that an organisational health promotion program is developed, implemented and evaluated. The program needs to be aimed at developing the capacity of the health service and strategically support health promotion action throughout the organisation. Much of the material written about health promoting health services tends to focus on health promotion activities, without acknowledging the important work that needs to happen ‘behind the scenes’ in order to develop the organisational infrastructure to support this activity. Johnson and Paton posit that the organisational health promotion program is fundamental to the success of reorienting a health service and requires as much attention as the health promotion activities themselves.\textsuperscript{25}

Johnson and Paton explain that an organisational health promotion program consists of a range of performance areas. These performance areas need to be
addressed in order to develop the infrastructure in the health service required to transform its leadership, mission and strategy, organisational culture, policies, management and clinical practices. They refer to the *Burke-Litwin Causal Model of Organisational Performance and Change*\(^8\) which is useful when thinking about the key performance areas for reorienting health services (Figure 5). This model identifies transformational and transactional levels of change as key to reorientation. This is a significant shift from the more traditional approach to change which focuses on using management policies and staff education as key strategies.\(^8\)

The *Burke-Litwin Causal Model of Organisational Performance and Change*\(^8\) expands people’s understanding of the need for a comprehensive and open systems model of change. It stresses the importance of the external environment in influencing change and differentiates between transformational level change (external environment, mission and statement, leadership, organisational culture) and transactional level change (structure, management practices, systems and work unit climate, motivation, task requirements and individual skills/abilities, individual needs and values, and individual organisation performance). These key performance areas inter-relate through feedback mechanisms. The connecting arrows in two directions represent the open-systems principle that change on one performance area will impact on other performance areas. It represents a gravity model of transformational change dynamics with the strongest performance areas at the top model.\(^8\)
Johnson and Paton note that many approaches to health promoting health services are based on strategies targeted towards transactional change, without careful consideration of the elements of transformational change required to support a reorientation process.\textsuperscript{25}

2.2.1.4.1.4 Health promotion sub-program categories
This component of the framework focuses on five health promotion sub-program categories. The five categories described are: 1) patient and families; 2) staff; 3) organisational; 4) physical environment; and 5) community. These categories exemplify the scope of health promotion activity within a health service.\textsuperscript{91}

2.2.1.4.1.4 Health promotion approach
Within or across the health promotion categories described above, a range of health promotion activities can be planned and implemented to reorient practice and the organisation from a focus on clinical care and rehabilitation of individuals to prevention and health promotion. To be effective, these activities need to incorporate the action areas of the Ottawa Charter for Health Promotion to ensure
focus is on population level health rather than just individual level care. Johnson states that to have the most impact health promotion activities cannot be ad hoc and implemented by individual staff members. Health promotion activity needs to be a whole-of-service response in partnership with communities and other agencies. Johnson notes that while a shift to population health is required, it is also important to maintain programs that focus on aspects of individual level care as reflected across the continuum of CPHC\textsuperscript{103} (Figure 6).

![Figure 6: Models of health and interventions for individual and population health actions – a continuum of primary health care](image)

The HPHSRF articulates the different components required to reorient a health service to become more health promoting. While health promotion activities are an important outcome of reorientation of health services, the value of this framework is on its first three components: the reorientation goal; foundation approaches; and organisational health promotion program. These components are valuable because they aim to develop organisational infrastructure to support health promotion practice and improved health outcomes. The model’s author acknowledges that while it is important to know what the requirements to reorient a health service are, knowing how to actually manage the change process is the key to successful reorientation.\textsuperscript{25} Providing guidance on how to manage the reorientation process, from a values base consistent with CPHC, is a distinct feature and key difference between this and other reorientation frameworks reviewed.
2.3 Conclusion

This literature review has focused on understanding how a health service can increase its capacity to deliver CPHC. Section one provided an overview of PHC, the renewed interest in PHC, the current state of PHC reform, and health promotion as a strategy to reorient organisations to deliver CPHC. Section two reviewed existing health service reorientation frameworks and case examples including: organisational capacity building; organisational change; and organisational development.

The research gaps identified in the literature review relate to: 1) the need for CPHC reorientation strategies to be based on organisational development that includes attention to both transformational and transactional change elements; and 2) for the impact of CPHC reorientation strategies based on organisational development to be evaluated.

Reorientation of health services to deliver CPHC is required to meet the current health reform imperatives in industrialised countries, including Australia. The current transition of Australia’s Divisions of General Practice Network into PHC Organisations means there is a need for access to information that provides clear guidance on how a health service can plan, implement and evaluate a strategy to reorient to CPHC. The development, implementation and evaluation of a Comprehensive Primary Health Care Organisational Development Strategy (CPHC ODS) at Far North Queensland Rural Division of General Practice (FNQRDGP) aligned with this need and responded to the identified research gaps.
3.0 Research design

This chapter describes the research design including: the research aim; research question and sub-questions; epistemology; theoretical perspective; methodology; theoretical frameworks; research participants; and data collection and analysis methods. The research project was approved by the Human Research Ethics Committee of the University of the Sunshine Coast in November 2008, approval number S/08/160 (Appendix 3).

3.1 Research aim

The aim of this research was to determine the degree of effectiveness of the Comprehensive Primary Health Care (CPHC) Organisational Development Strategy (ODS) as a reform mechanism for reorientation of a health service program to a CPHC delivery approach.

3.2 Research questions

Overall research question:

1. What is the impact of a CPHC ODS on the capacity of FNQRDGP to deliver CPHC?

Sub questions:

1. What is the impact of a CPHC ODS on FNQRDGP’s workforce processes?
2. What is the impact of a CPHC ODS on FNQRDGP’s organisational processes?
3. What is the impact of a CPHC ODS on FNQRDGP’s organisational culture?

3.3 Epistemology

Epistemology is the philosophical understanding and explanation about the nature of knowledge and how people come to know.\textsuperscript{105} This research project is positioned within a constructivist epistemology which emphasises that humans generate knowledge and meaning through interactions between their experiences and
Constructivism places emphasis on the unique experience of each individual and suggests each person’s way of making sense of the world is equally valid and worthy of respect. Knowledge and truth are therefore the result of perspective and the existence of objective knowledge is denied.

Constructivist researchers are interested in the co-construction of knowledge between the researcher and the researched and assume many interpretations of the same data are possible, all of which are potentially meaningful. Knowledge constructions are not separate from those who make them; the researchers are not part of an ‘objective’ world that exists separate from research participants. Knowledge that emerges from research participants is, at least in part, created, not discovered, by the researcher. Knowledge and interpretation in a constructivist epistemology is therefore the result of a collective, not an individual, process. The following three points are considered important when undertaking constructivist research:

1. The assumptions we as researchers bring to our subject of inquiry and to the research situation;
2. The socially constructed meanings that occur in the context of the research process; and
3. The socially constructed meanings that existed prior to, and shape or limit, the meanings that may emerge through data analysis process.

A constructivist epistemology is consistent with this research project because epistemologically it supports the notion of ‘co-creation’ of knowledge and understanding drawn from participants’ perceptions and actual experiences.

3.4 Theoretical perspective

Critical theory is the theoretical perspective that underpinned this research. Critical theory focuses on critiquing and understanding inequities in society. Understanding inequities between people is developed by examining relationships of power and the underlying structures in society that produce them. Social
structures that determine the distribution of wealth, access to education, and the availability of healthcare services are often made to appear inevitable, natural, and constant. However, an assumption of critical theory is that cultural, political, and economic circumstances in society are not natural and fixed, but are historically created and alterable to serve the needs of those who hold power.

Critical theory advocates for a type of consciousness that explores how these social structures operate to oppress some members of society while systematically privileging others. Therefore, it seeks to challenge conventional assumptions and social arrangements to move beyond the "what is" to the "what could be". Critical theory aims to create knowledge that enables human beings to emancipate themselves from forms of domination through self-reflection.

Therefore, research as an activity addresses the oppressive social structures, initially by understanding them, and then using research findings to secure change(s). This means the critical researcher aims for a transformative outcome, and thus is not interested in "knowledge for knowledge's sake". It aligns well with the aim of public health research which is not just to understand, but to use understanding to bring about change.

The basic tenants of critical theory are well aligned with key values and principles of CPHC: social justice, empowerment and equitable access to health services. Similar to critical theory, CPHC focuses on addressing inequities in health care systems to improve health outcomes. The need to reorient health services to CPHC is concerned with better health care for all people, regardless of class, ethnicity or social and political agendas. Critical theory was therefore an appropriate theoretical perspective to guide this research as it supports system change to improve people’s lives.
3.5 Research methodology

Evaluation research was the methodology used in this research. Evaluation research is a form of applied research that aims to solve specific policy problems or help practitioners accomplish tasks. The key strength of evaluation research is the immediate application of evaluation findings in practice environments.\textsuperscript{116}

3.5.1 Evaluation research

Evaluation research is the process used to decide the worth or value of something.\textsuperscript{117-119} Assessing the value of something involves measurement, observation and comparison with a criterion or standard.\textsuperscript{71, 120} Common measurement standards usually relate to appropriateness, effectiveness, efficiency and equity.\textsuperscript{118}

Evaluation research is crucial for assessing the effect of a program and its strategies and activities.\textsuperscript{120} Evaluation research addresses the question, ‘Did a program work?’ To assess if a program worked, evaluation research: identifies what has been done; finds value in why it has been done; and develops understanding about how improvements can be made in the future to enhance success.\textsuperscript{93, 115, 119, 121, 122} Evaluation research is undertaken for a range of reasons:\textsuperscript{115}

- To assess the outcomes of a program and measure its success using a variety of indicators;
- To review a program’s processes and enhance the understanding of what has been achieved;
- To assess satisfaction with programs;
- To identify efficient ways of achieving desired outcomes;
- To account for resources received and make a case for their continuation;
- To generate knowledge for use influencing policy makers;
• To contribute to the development of the broad knowledge and theory base of a discipline, including its evidence base; and
• To provide information about a project during its progress that can be used to make modifications and enhance the achievement of aims.

Evaluation can take a number of different forms and use a variety of approaches and methods. The approach used in this research project was the Health Promotion Planning and Evaluation Cycle. The cycle has seven stages across the planning, implementation and evaluation phases of a health promotion program: 1. Problem definition; 2. Solution generation; 3. Resource mobilisation; 4. Implementation; 5. Impact assessment; 6. Intermediate outcome assessment; and 7. Outcome assessment. Each stage of cycle is presented in Figure 7 and described below.

Figure 7: Health Promotion Planning and Evaluation Cycle

Impact evaluation of a CPHC ODS on a health service’s capacity to deliver comprehensive primary health care
Stage 1: Problem definition; starting at the end

Problem definition defines a health problem from a range of stakeholder perspectives. When defining a health problem it is important to take account of:

- The prevalence of the problem (the number of people affected) and whether the prevalence varies between subgroups (such as older adults, adolescents, people from socially or culturally diverse groups);
- The public health impact of the problem (the seriousness of the consequences of the problem for the individuals affected and the population as a whole); and
- The potential for intervention (whether factors that impact the problem can be changed and the scale of the health improvement that could be achieved if the problem were reduced or abolished).

The analysis of this evidence should then lead to the development of measurable health promotion program goals and objectives that form the basis of a program plan. In this way, the beginning of the planning process clearly identifies the impact and outcome measures required for evaluation.

Stage 2: Solution generation

Solution generation involves the analysis of potential solutions to inform the development of program strategies and activities. It indicates the timing and sequencing of strategies and activities in order to achieve maximum effect.

Stage 3: Resource mobilisation: creating the right conditions

Resource mobilisation involves obtaining the resources (such as money, staff, and materials) required for the successful implementation of a program. It also involves building capacity within a community and/or organisation so that a program can be introduced and sustained.

Stage 4: Implementation
The implementation of a program involves the implementation and evaluation of program strategies and activities to achieve the program objectives and goals. At this stage the primary aim is to ensure that a program is implemented as closely as possible to the original plan.

Stage 5, 6 and 7: Evaluation

Health promotion strategies can be expected to have different types of impact and different effects over time. Consequently, different evaluation methods are used to measure impact and outcome level changes at different stages across the life of a program. Stages five, six and seven of the cycle focus on three different levels of evaluation:

- Stage 5: Impact assessment;
- Stage 6: Intermediate assessment; and
- Stage 7: Outcome assessment.

Stage 5: Impact assessment

Impact assessment measures the achievement of immediate or short-term program objectives defined during Stage 1 of the program. Although the term ‘impact assessment’ is used in this model, impact evaluation is the more common term for this level of evaluation. Impact evaluation is the term used in this research project. Impact evaluation generally relates to changes in:

- Health literacy: knowledge, attitudes, motivation, personal skills, behaviour intentions and self-efficacy;
- Social action and influence: community participation, community empowerment, social norms and public opinion; and
- Healthy public policy and organisational practice: policy statements, legislation, regulation, resource allocation and organisational practices.

These impacts are intended to lead to subsequent changes in intermediate health outcomes such as behaviours and environments that ultimately contribute to improved health and social outcomes.
The key tasks in undertaking impact evaluation are to:\textsuperscript{120}

1. Identify the impact indicators to be used;
2. Establish the target levels for the impact indicators;
3. Identify the data to be collected and methods of doing this;
4. Design the evaluation to increase the likelihood that observed effects can be attributed to the health promotion program;
5. Implement the impact assessment; and

In this research project, impact evaluation tasks were carried across stages one to five of the Health Promotion Planning and Evaluation Cycle. Tasks one to four were carried out in \textit{Stage 2: Solution generation} and tasks five and six were carried out in \textit{Stage 5: Impact assessment}. The application of these stages and tasks to this research project is presented in Table 9 below.

\textit{Stage 6: Intermediate assessment}

Intermediate assessment measures the longer-term impacts of programs on individual behaviour or social, economic and environmental conditions that determine health. These measures generally relate to changes in:

- \textit{Healthy lifestyles}: tobacco use, physical activity, food choices and alcohol and illicit drug use;
- \textit{Effective preventive health service}: access to the provision of relevant and preventive services; and
- \textit{Healthy environments}: safe physical environment, supportive economic and social conditions, good food supply and restricted access to tobacco/alcohol.

\textit{Stage 7: Outcome assessment}

Outcome assessment involves the measurement of long-term or endpoint outcomes. These measures generally relate to changes in:
- **Social outcomes**: quality of life, functional independence, social capital and equity; and
- **Health outcomes**: reduced morbidity, reduced disability and avoidable mortality.

Achievement of changes in these health outcomes is dependent on the achievement of changes in shorter-term impact and intermediate level determinants.

This research project utilised the first five stages of the Health Promotion Planning and Evaluation Cycle. Stages six and seven relate to intermediate impacts and health outcome level changes which were beyond the scope and timeframe of this research project.

### 3.6 Theoretical frameworks

Two theoretical frameworks were used in this research project:

1. Framework for Building Capacity to Improve Health,\(^{85}\) and
2. Health Promoting Health Services Reorientation Framework (HPHSRF).\(^{25}\)

The Framework for Building Capacity to Improve Health was used to understand the range of indicators necessary to increase an organisation’s capacity to be more health promoting. It provided specifics about *what* FNQRDGP needed to change to increase capacity to deliver CPHC. The HPHSRF was used to understand the management of organisational change and the reorientation process. It provided specifics about *how* FNQRDGP needed to manage the organisational change process.
Table 9: Application of evaluation stages and tasks in research project

<table>
<thead>
<tr>
<th>Stage 1: Problem definition</th>
<th>Stage 2: Solution generation</th>
<th>Stage 3: Resource mobilisation</th>
<th>Stage 4: Implementation</th>
<th>Stage 5: Impact assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Define health problem</td>
<td>• Analysis of potential solutions</td>
<td>• Obtain resources</td>
<td>• Implement program</td>
<td>• Short-term/immediate change in organisation’s practices</td>
</tr>
<tr>
<td>• Understand community or organisation’s needs and priorities</td>
<td>• Develop program plan</td>
<td>• Build capacity in organisation</td>
<td>Key tasks</td>
<td>Key tasks</td>
</tr>
<tr>
<td></td>
<td>Key tasks</td>
<td></td>
<td></td>
<td>5. Implement impact assessment</td>
</tr>
<tr>
<td></td>
<td>1. Identify impact indicators</td>
<td></td>
<td></td>
<td>6. Report impact assessment</td>
</tr>
<tr>
<td></td>
<td>2. Establish target levels for impact indicators</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Identify information to be collected and preferred methods</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Design evaluation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Identified gap in evaluated CPHC organisational capacity building strategies</td>
<td>• Identified CPHC organisational capacity building strategies</td>
<td>• Obtained organisational support, commitment and resources to implement the CPHC ODS</td>
<td>• Implemented CPHC ODS*</td>
<td>• Assessed FNQRDGP’s capacity to deliver CPHC pre, interim and post time ODS implementation</td>
</tr>
<tr>
<td>• FNQRDGP wants to increase capacity to deliver CPHC</td>
<td>• Developed program plan to implement and evaluate a CPHC organisational development strategy (ODS)</td>
<td>Key tasks</td>
<td>Key tasks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Key tasks</td>
<td>1. Developed 37 indicators to assess FNQRDGP’s capacity: Capacity Indicator Framework*</td>
<td>5. Conducted questionnaires and interviews pre, interim and post CPHC ODS implementation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Identified participants’ perceptions of FNQRDGP’s capacity to deliver CPHC</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Developed questionnaire and individual semi-structured interview protocol **</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Identified gap in evaluated CPHC organisational capacity building strategies</td>
<td>• Identified CPHC organisational capacity building strategies</td>
<td>• Obtained organisational support, commitment and resources to implement the CPHC ODS</td>
<td>• Implemented CPHC ODS*</td>
<td>• Assessed FNQRDGP’s capacity to deliver CPHC pre, interim and post time ODS implementation</td>
</tr>
<tr>
<td>• FNQRDGP wants to increase capacity to deliver CPHC</td>
<td>• Developed program plan to implement and evaluate a CPHC organisational development strategy (ODS)</td>
<td>Key tasks</td>
<td>Key tasks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Key tasks</td>
<td>1. Developed 37 indicators to assess FNQRDGP’s capacity: Capacity Indicator Framework*</td>
<td>5. Conducted questionnaires and interviews pre, interim and post CPHC ODS implementation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Identified participants’ perceptions of FNQRDGP’s capacity to deliver CPHC</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Developed questionnaire and individual semi-structured interview protocol **</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Described in section 3.6
**Described in section 3.8
The two frameworks were used to develop the following:

1. Capacity Indicator Framework (CIF);
2. Impact evaluation instrument; and
3. CPHC ODS.

The development of the CIF, impact evaluation instrument and CPHC ODS are presented in Figure 8 and described below.

**Figure 8: Relationship between theoretical frameworks and project outputs**

### 3.6.1 Capacity Indicator Framework

The CIF was developed by the PHC Manager to ascertain key components, sub components and indicators of organisational capacity necessary to deliver CPHC (Appendix 4). There were three key components, eight sub-components and 37 indicators.
The three components included workforce development, organisational processes and organisational culture. Workforce development sub components (and the number of related indicators for each sub component) included: 1) *opportunities* (three indicators); and 2) *task requirements* (two indicators).

Organisational processes had four subcomponents: 1) *organisational systems* (eight indicators); 2) *organisational structures* (four indicators); 3) *organisational leadership* (six indicators); and 4) *external environment* (two indicators).

Organisational culture subcomponents included: 1) overall *view of the organisation* (nine indicators); and 2) *health promotion culture* (three indicators).

### 3.6.2 Impact evaluation assessment tool

The purpose of the impact evaluation assessment tool was to assess short-term, impact-level changes in FNQRDGPs’s capacity to deliver CPHC. The PHC Manager used the CIF as the basis for structuring the assessment tool. The assessment tool included organisational capacity components, subcomponents and indicators from the CIF. An ascending nine-point numerical scale was then added to each CIF indicator to assess FNQRDGPs performance in reference to each indicator. This nine-point scale was adapted from Skinner and Botelho’s *Organisational Prototype* (2001)\(^{27}\) referred to in the HPHSRF.

The ascending nine-point scale was organised into three response categories to indicate the level at which an organisation is delivering CPHC practice: *Reactive* (1-3), *Proactive* (4-6) and *High Performing* (7-9) (Table 10). The *Reactive* response category classifies an organisation as demonstrating limited CPHC practices. The *Proactive* response category classifies an organisation as demonstrating some CPHC practices. The *High Performing* response category classifies an organisation as demonstrating extensive CPHC practices.
The impact evaluation assessment tool was then used to collect quantitative impact evaluation data (described in detail in section 3.8).

3.6.3 Comprehensive Primary Health Care Organisational Development Strategy

The purpose of the CPHC ODS was to increase FNQRDGP’s capacity to deliver CPHC (Figure 9). The CPHC ODS was developed, implemented and evaluated by the PHC Manager between April 2007 and May 2009. The CPHC ODS included two simultaneous parts. Part one comprised a set of interactive and complementary CPHC and health promotion focused activities. Activities addressed CIF component indicators (workforce development, organisational processes and organisational culture) where there was no CPHC activity being undertaken within the organisation at the time. Activities were determined following the PHC Manager’s observations about what was already in place, and participant pre and interim interview data (see section 3.8). The scope of the CPHC ODS activities ranged from changes in position descriptions to include CPHC and health promotion responsibilities to reviewing organisational policy to ensure CPHC practice was structured into employees’ everyday practice. The full range of CPHC ODS activities is presented in Appendix 5.

Part two of the CPHC ODS was an organisational change process used by the PHC Manager to understand how to manage the implementation of the activities. The organisational change process was based on the *Paton-Johnson Model of Change Management* (2004)\(^{25}\) and Johnson’s *Health Promoting Health Services*: 

<table>
<thead>
<tr>
<th>Organisational Systems</th>
<th>Reactive</th>
<th>Proactive</th>
<th>High performing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisational policies and processes</td>
<td>Limited reference to comprehensive primary health care delivery</td>
<td>General reference to comprehensive primary health care delivery</td>
<td>Specific and consistent reference to comprehensive primary health care delivery</td>
</tr>
<tr>
<td>1 2 3</td>
<td>4 5 6</td>
<td>7 8 9</td>
<td></td>
</tr>
</tbody>
</table>

Table 10: Sample questionnaire item displaying response categories and three point scale within each category
Organisational and Activities Practice Assessment Tool (2006)\textsuperscript{25} which are both key components of the HPHSRF. The application of the change management model and the assessment tool within the CPHC ODS is presented in Table 11.

![Diagram of CPHC-Focused Organisational Development Strategy]

**Figure 9: Comprehensive Primary Health Care Organisational Development Strategy**
### Table 11: Application of Paton-Johnson Model for Change Management

<table>
<thead>
<tr>
<th>Sequential stages</th>
<th>Stage 1: Conversations about change</th>
<th>Application in this research</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Create readiness for change</td>
<td>• Held discussions with team and management about the importance of reorienting to CPHC and how to do this</td>
</tr>
<tr>
<td></td>
<td>• Build alliance or critical mass of people interested in change</td>
<td>• Obtained organisational support, commitment and resources to implement the CPHC ODS</td>
</tr>
<tr>
<td></td>
<td>• Consider the ‘why’ and ‘how’ – why the change is needed and how it can be achieved</td>
<td>• Identified team members who may resist change and considered why</td>
</tr>
<tr>
<td></td>
<td>• Identify and mobilise resources needed to support change</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Identify who is likely to resist proposed change: who will be threatened; who may oppose it and why; what can be done to manage resistance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stage 2: Diagnosis</td>
<td>Application in this research</td>
</tr>
<tr>
<td></td>
<td>• Understand what happens ‘now’ in an organisation: How do people work now; How are services provided now?; How do people behave now?; How can health services make a greater impact on the communities it services now?; What changes need to be considered to make this impact?</td>
<td>• Developed CIF based on identified theoretical frameworks and tools</td>
</tr>
<tr>
<td></td>
<td>• Methods to conduct a diagnosis of situation now:</td>
<td>• Developed assessment tool to assess FNRDGPs capacity to deliver CPHC</td>
</tr>
<tr>
<td></td>
<td>Johnson’s Health Promoting Health Services: Organisational and Activities Assessment Tool (2006); Skinner and Botelho’s Organisational Prototype (2001); interviews with staff; observation; questionnaires; and document analysis</td>
<td>• Collected data on participant perceptions of FNQRDGPs capacity to deliver CPHC: administered questionnaire, conducted semi-structured individual interviews</td>
</tr>
<tr>
<td></td>
<td>• Developed CIF based on identified theoretical frameworks and tools</td>
<td>• Analysed questionnaire and interview data to determine current situation</td>
</tr>
<tr>
<td></td>
<td>Stage 3: Develop vision</td>
<td>Application in this research</td>
</tr>
<tr>
<td></td>
<td>• Identify future vision</td>
<td>• Developed CPHC vision from CIF, participant questionnaire and interview results and available resources</td>
</tr>
<tr>
<td></td>
<td>• Be inclusive and participatory</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Realistic, achievable, inspirational and communicable</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stage 4: Plan for change (simultaneous activities)</td>
<td>Application in this research</td>
</tr>
<tr>
<td></td>
<td>• What is going to happen to make change come about?</td>
<td>• Developed plan for CPHC ODS based on CIF and participant questionnaire and interview results</td>
</tr>
<tr>
<td></td>
<td>• Simultaneous activities related to each other</td>
<td>• Spent time with staff who resisted change</td>
</tr>
<tr>
<td></td>
<td>Resistance management:</td>
<td>• Provided forums for discussion about the change process</td>
</tr>
<tr>
<td></td>
<td>• Identify who will resist proposed change and reasons;</td>
<td>• Established CPHC communication network (email list serves, meetings, updates)</td>
</tr>
<tr>
<td></td>
<td>• Help manage resistance (provide support for people who feel threatened);</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Establish communication systems to: communicate need for change; what is being planned; progress being made; forums to voice concerns and debate; opportunities for active involvement in planning and implementation of change</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Commitment management:</td>
<td>• Implemented whole-of-team planning and training days with CEO and Operations Manager present</td>
</tr>
<tr>
<td></td>
<td>• Build and develop commitment to change process</td>
<td>• Developed and delivered a range of CPHC and health promotion professional development opportunities for team</td>
</tr>
<tr>
<td></td>
<td>• Understand what’s important to people</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Gain visible support from powerful and influential people</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Celebrate and publicise successes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Secure resources for sustainable change</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Developing and investing in people:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Range of activities to develop people’s skills and knowledge, attitudes and values to enable them work in new ways</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Techno-structure activity:</td>
<td>• Re-structured Health Promotion Practitioner roles</td>
</tr>
<tr>
<td></td>
<td>• Organisation structure or re-structure</td>
<td>• Established CPHC communication network</td>
</tr>
<tr>
<td></td>
<td>• Information and communication systems</td>
<td>• Established CPHC-focused work procedures and policies</td>
</tr>
<tr>
<td></td>
<td>• Formal work procedures, processes and protocols</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Culture change program:</td>
<td>• Held team-building days</td>
</tr>
<tr>
<td></td>
<td>• Changes in attitudes, values and behaviours</td>
<td>• Inclusion of CPHC in all team functions and organisational practices</td>
</tr>
</tbody>
</table>
3.7 Research participants

The research participants included members of the FNQRDGP’s Cape York Primary Health Care programs who were selected through purposive sampling. The criterion for research involvement was having direct experience and responsibilities to deliver CPHC programs and services.

Members of the Cape York Primary Health Care programs received an email message (Appendix 6) from the researcher inviting them to participate in the research project. The Research Project Information Sheet (Appendix 7) and Consent Form (Appendix 8) were attached to the email. Those who agreed to participate were required to complete and submit the consent form prior to participating in the research project. Participants were then required to complete a questionnaire at two time points: 1. at the interim time period of the CPHC ODS implementation and; 2. post implementation of the CPHC ODS. At the interim time point, participants completed two questionnaires; one relating to the pre time point and the other relating to the interim time point. Participants participated in individual semi-structured interviews following the completion of the questionnaire at the interim time point and the post time point. The time frame for the development, implementation and evaluation of the CPHC ODS is presented in Figure 10.

![Figure 10: Time frame for development, implementation and evaluation of the CPHC ODS](image-url)
3.8 Research data collection and analysis methods

Two research methods were used to collect and analyse the impact evaluation data: 1. Questionnaire; and 2. Semi-structured individual interviews. The purpose, data collection and analysis process, and data source for both methods are described and summarised below in Table 12.

Table 12: Summary of research methods

<table>
<thead>
<tr>
<th>Impact evaluation of ODS implementation</th>
<th>Method and purpose</th>
<th>Data collection</th>
<th>Data analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Method 1: Questionnaire</td>
<td></td>
<td>Collected quantitative data for three time points:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Purpose: To collect quantitative data about participants’ perceptions of organisational practices that impact on FNQRDGP’s capacity to deliver CPHC</td>
<td>1. Pre ODS implementation - baseline data</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Six months post ODS implementation - interim impact evaluation data and data to inform the ongoing development of ODS</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. 12 months post ODS implementation - impact evaluation data</td>
<td></td>
</tr>
<tr>
<td>Method 2: Semi-structured individual interviews</td>
<td>Purpose: To collect qualitative data about why participants rated questionnaire items as they did</td>
<td>Collected qualitative data for three time points:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Pre ODS implementation- baseline data</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Six months post ODS implementation - interim impact evaluation and informed the ongoing development of ODS</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. 12 months post ODS implementation - impact evaluation data</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Data were:</td>
<td>• Coded and entered into SPSS 17</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Used to generate descriptive statistics all variables and tested for normality</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Used to conduct parametric statistical tests</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Analysed using Independent Samples t test to compare how participants rated FNQRDGP’s capacity to deliver CPHC across pre, interim and post time points</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Data were:</td>
<td>• Entered into NVIVO 8 software program</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Analysed in reference to the CIF</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Themed using an adaptation of Ritchie and Spencer’s five stage qualitative data analysis process: Familiarisation; Identification of a thematic framework; Indexing; Charting; Mapping and interpretation.</td>
<td></td>
</tr>
</tbody>
</table>

3.8.1 Research method one: Questionnaire

3.8.1.1 Purpose

The purpose of the questionnaire was to collect quantitative data on research participants’ perceptions about organisational practices that impact on FNQRDGP’s capacity to deliver CPHC. The data collected served two purposes:

1. Assessing FNQRDGP’s capacity to deliver CPHC pre, interim and post ODS implementation; and
2. Informing the ongoing development of the ODS at the interim time point.
3.8.1.2 Data collection
The data collection instrument was a self-administered questionnaire called the Questionnaire to Assess Organisational Capacity to Deliver Comprehensive Primary Health Care (Appendix 9). The questionnaire was administered twice and collected impact evaluation data for three time points: pre, interim and post (Table 11).

The first administration collected data for two time points:
1. Pre time point data were used to assess FNQRDGP’s capacity to deliver CPHC prior to the implementation of the CPHC ODS.
2. Interim time point data were used to assess FNQRDGP’s capacity to deliver CPHC six months post ODS implementation. Data informed the ongoing development of the ODS.

The second administration collected data for one time point:
3. Post time point data were used to assess FNQRDGP’s capacity to deliver CPHC 12 months post ODS implementation. These data were used to evaluate the effect of the ODS 12 months post implementation.

Pre and interim data were collected simultaneously at the first data collection time point because the CPHC ODS commenced sooner than anticipated. Therefore, baseline data were collected retrospectively in reference to a specific event familiar to all participants.

As described in section 3.6.2, participants rated each indicator according to the three response categories: reactive, proactive, high performing, and within each category on a three point scale. At both administration points, participants had seven days to complete the questionnaire prior to individual interviews with an independent (third party) interviewer. Participants were asked to bring the completed questionnaire to their interview.

3.8.1.3 Data analysis
Questionnaire data were analysed in reference to relevant research sub-questions with the assistance of SPSS 17\textsuperscript{125} in six stages. In stage one, data were coded and entered into SPSS 17. Each participant’s data were checked to
ensure all codes were entered correctly. A frequency check was then conducted on all variables to pick up any data-entry errors.

To enhance the interpretability of the results with respect to the three response categories, data were recoded from a scale of 1 to 9 to a scale of 1 to 3. Responses in the reactive category were recoded from 1, 2 and 3 on the original scale to 1, 1.3 and 1.6 respectively on the revised scale; responses in the proactive category were recoded from 4, 5 and 6 to 1.7, 2.0 and 2.3; and responses in the high performing category were recoded from 7, 8 and 9 to 2.4, 2.7 and 3.

In stage two, descriptive statistics were generated for each variable and tested for normality. Data were not normally distributed, therefore non-parametric statistical analyses would normally be conducted. However, because the questionnaire had 37 individual items (variables), each with identical response categories, central limit theorem was employed. Central limit theorem states that the mean of a sufficiently large number of independent random variables, each with finite mean and variance, will be approximately normally distributed and therefore parametric statistical analysis should be used.126

Stage three involved using the Independent Samples t test to determine the differences in means for each of the 37 indicators across the pre, interim and post time points. The t tests are based on the assumption of homogeneity of variance. Levene’s Test for Equality of Variances was used to test this assumption. Where the assumption was violated for t tests, the t test result where equal variances not assumed is reported.

Stage four identified indicators with statistically significant differences between pre and interim, pre and post, and interim and post time points.

Stage five assessed the magnitude of the effect size using Cohen’s $d$ for those indicators with statistically significant differences between any two time points. Cohen’s $d$ effect size categories are: trivial; small; moderate; large; very large; nearly perfect; and perfect127 (Table 13).
Stage six assessed the proportion of indicators that demonstrated statistically significant differences across the three time points in relation to each research sub-question. The proportion of indicators that moved in a positive or negative direction between Reactive and Proactive; Proactive and High Performing; and Reactive and High Performing is reported. The proportion of indicators that remained at the same category is also reported.

3.8.2 Research method two: Semi-structured individual interviews

3.8.2.1 Purpose

The purpose of the individual semi-structured interviews was to collect qualitative data about why participants rated questionnaire indicators the way they did at the pre, interim and post time points. The data served two purposes:

1. Assessing FNQRDGP’s capacity to deliver CPHC pre, interim and post ODS implementation.
2. Informing the ongoing development of the ODS at the interim time point.

3.8.2.2 Data collection

Interviews were conducted after participants completed the questionnaire at the interim and post time points. An independent interviewer conducted the interviews and each interview took between 35 and 60 minutes. At the commencement of each interview the interviewer provided an overview of the interview process. The discussion between the participant and interviewer was guided by the participant’s responses to the questionnaire. For example, the interviewer may have asked “I see you have rated Structure of Health Promotion as a three, can you tell me the reasons you rated it this way?”

Interviews were recorded on a mini disc and later transcribed into a Word text file by a professional transcription service. Interview transcripts were provided to...

Table 13: Cohen’s $d$ effect size categories

<table>
<thead>
<tr>
<th>Cohen’s $d$</th>
<th>0.0</th>
<th>0.2</th>
<th>0.6</th>
<th>1.2</th>
<th>2.0</th>
<th>4.0</th>
<th>Infinite</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effect size category</td>
<td>Trivial</td>
<td>Small</td>
<td>Moderate</td>
<td>Large</td>
<td>Very large</td>
<td>Nearly perfect</td>
<td>Perfect</td>
</tr>
</tbody>
</table>

Impact evaluation of a CPHC ODS on a health service’s capacity to deliver comprehensive primary health care
interviewees electronically for their review and endorsement prior to integration of interview data for analysis. Identifying information such as names was removed by the independent interviewer prior to transcripts being provided to the researcher.

3.8.2.3 Data analysis

Qualitative data were entered into QSR NVIVO 8 software program\textsuperscript{128} with reference to the CIF structure. The data were then analysed by the researcher using an adaptation of Ritchie and Spencer’s\textsuperscript{129} five stage qualitative data analysis process (Table 14).

Table 14: Qualitative data analysis process for interviews

<table>
<thead>
<tr>
<th>Stage</th>
<th>Action</th>
</tr>
</thead>
</table>
| **Stage 1 - Familiarisation** (with data) | (1) Read and re-read key organisational documents  
(2) Noted key ideas and themes that emerged from the data in reference to the CIF |
| **Stage 2 - Identification of a thematic framework** (key themes emerging from the data) | (3) Critically reflected on data generally to identify key themes that were not reflected in CIF |
| **Stage 3 – Indexing** (application of thematic framework to data via thematic referencing) | (4) Coded and allocated data to relevant CIF items |
| **Stage 4 - Charting** (re-arranging data from original context to the appropriate thematic reference) | (5) Reviewed data to ensure that all data were allocated to the appropriate item and re-chorted if necessary |
| **Stage 5 - Mapping and interpretation** (reviewing themes for connections and patterns and seeking explanations for these) | (6) Reviewed themes within and across items and categories for connections and patterns and proposed explanations  
(7) Assessed data in reference to the Primary Health Care indicator continuum in the CIF |

3.9 Conclusion

This chapter has described the research design including the research aim, research question and sub-questions, epistemology, theoretical perspective, methodology, theoretical frameworks, research participants, and data collection and analysis methods.

This research was positioned within a constructivist epistemology. The theoretical perspective was critical theory and evaluation research was the research methodology. Two theoretical frameworks, Framework for Building Capacity to Improve Health and the Health Promoting Health Services Reorientation Framework guided the development of the: 1. Capacity Indicator Framework; 2. Impact evaluation assessment tool; and 3. CPHC ODS.
The CIF was developed to ascertain key components, sub components and indicators of organisational capacity necessary to deliver CPHC. The impact assessment evaluation tool was developed to assess short-term, impact-level changes in FNQRDGP’s capacity to deliver CPHC pre, interim and post CPHC ODS implementation. The CPHC ODS was developed to increase FNQRDGP’s capacity to deliver CPHC.

Research participants were staff from FNQRDGP’s Primary Health Care programs. Participants completed the questionnaire at two time points interim and post CPHC ODS implementation, providing data related to three time points: pre, interim and post CPHC ODS implementation. They also participated in semi-structured individual interviews after completing the questionnaire to ascertain why they rated FNQRDGP’s capacity to deliver CPHC the way they did. Quantitative questionnaire data were coded and entered into SPSS 17. Statistical tests were conducted in reference to the research question and sub questions. Qualitative interview data were entered and coded in NVIVO 8. Analysis was guided by Ritchie and Spencer’s 5 stage qualitative data analysis method.

The research results are presented in the following chapter.
4.0 Results
Chapter four presents the research results of the impact evaluation of the CPHC ODS. It commences with a description of research participants, followed by the results for each of the three research sub-questions. This includes results related to the impact of the CPHC ODS on: 1) Workforce Development Processes; 2) Organisational Processes; and 3) Organisational Culture. The results for the overall research question are then presented.

4.1 Description of participants
Thirteen staff participated in the research. At the time of pre and interim data collection, 11 participants were health professionals and two worked in administration. At the time of post data collection, 12 participants were health professionals and one was a manager.

4.2 Changes in FNQRDGP’s capacity to deliver CPHC
Changes in FNQRDGP’s capacity to deliver CPHC are reported in two sections. The first section is organised in three parts: 1) research sub-question one results; 2) research sub-question two results; and 3) research sub-question three results. Quantitative and qualitative results for each of the CIF’s 37 indicators across the three time points are reported. Each part concludes with a summary of the research sub-question results for the pre, interim and post time points. The second section reports results for the overall research question pre and post implementation of the CPHC ODS (Table 15).
Table 15: Results reporting structure

<table>
<thead>
<tr>
<th>Section one</th>
<th>Section two</th>
</tr>
</thead>
<tbody>
<tr>
<td>Results</td>
<td>Research sub-question/question</td>
</tr>
</tbody>
</table>
| Research sub-question results reported against 37 indicators relevant to CIF’s components and sub-components | 1. What is the impact of a CPHC ODS on FNQRDGP’s workforce development processes? | 1. Workforce development  
   i. Opportunities  
   ii. Task Requirements |
| | 2. What is the impact of a CPHC ODS on FNQRDGP’s organisational processes? | 2. Organisational Processes  
   iii. Organisational systems  
   iv. Organisational structures  
   v. Organisational leadership  
   vi. External environment |
| | 3. What is the impact of a CPHC ODS on FNQRDGP’s organisational culture? | 3. Organisational Culture  
   vii. Overview of the organisation  
   viii. Health promotion culture |
| Changes in reference to the overall research question | 1. What is the impact of a CPHC ODS on FNQRDGP’s capacity to deliver CPHC | CPHC ODS components and sub-components |

4.2.1 Research sub-question results

For each indicator, quantitative results are reported followed by qualitative results. Within the quantitative results the mean response at each time point is reported on a three point scale, followed by the standard deviation in parentheses. This is followed by the differences in means between each pair of time points, with 95% confidence intervals in parentheses. The results of Independent Samples t tests for significant differences between means are presented, including the degrees of freedom, t test statistic, p value and Cohen’s d statistic for effect size. Within the qualitative results, enabling factors and barriers that impacted on FNQRDGP’s capacity to deliver CPHC are reported. Relevant direct quotes from participants are then presented for each indicator.

4.2.1.1 Research sub-question one results

Research sub-question one asked: What is the impact of a CPHC ODS on FNQRDGP’s workforce development processes? Impact on workforce development processes was assessed against five CPHC indicators (Refer to Appendix 10). Results for each indicator are described below.
4.2.1.1 Staff able or supported to conduct CPHC

At the pre time point, the mean response for the indicator ‘Staff able or supported to conduct CPHC’ was 1.6 (SD=0.8), placing it in the Reactive category. At the interim time point, the mean response was 2.5 (SD=0.5), placing it in the High Performing category. At the post time point, the mean response was 2.7 (SD=0.5), also in the High Performing category.

The difference between the sample mean scores was: 1.0 (95% CI 0.3-1.6) between pre and interim time points; 0.1 (95% CI -0.3-0.6) between the interim and post time points; and 1.1 (95% CI 0.4-1.8) between pre and post time points. Participants reported significantly higher scores at the interim time point compared to the pre time point (t(16 degrees of freedom)=3.175, p=0.006, d=1.5) and significantly higher scores at the post time point compared to the pre time point (t(14)=3.4, p=0.004, d=1.7) (Figure 11). There was no significant difference between scores at the interim and post time points (t(18)=0.526, p=0.605).

In the post program interviews, participants reported a positive impact on their ability to conduct CPHC over the 12-month period. Four key enabling factors

![Figure 11: Mean scores for Comprehensive Primary Health Care Indicator ‘Staff able/supported to conduct Comprehensive Primary Health Care’ at pre, interim and post time points](image-url)
were identified: leadership; resources (human and physical); health promotion action plans and reporting processes; and the recruitment process.

**Characteristics of managers**

Having a manager with an in-depth understanding of the links between health promotion and CPHC was a key enabler of ability to conduct CPHC. Participants also identified certain characteristics of managers considered important:

*A key ingredient to supporting staff to deliver CPHC is the knowledge being given from management. Our manager has been motivational and is really keen on comprehensive health care initiatives. If you’ve got managers who believe in [CPHC], that flows onto staff.* (ID03)

*I think a lot of changes happen because we have managers who are passionate and share these ideas and teach us or show us, lead by example. They engender drive and ownership in us. They say ‘this is your discipline, you go out and be a change agent’ and then we’re allowed to do that* (ID05).

**Resources**

Human and physical resources were identified as being important enablers. Participants highlighted the need for health promotion practitioners to support the team in the development, implementation and evaluation of health promotion programs. Participants also identified the importance of efficient access to physical resources, such as vehicles and money to conduct community-based activities outside of health clinics:

*What I need to be able to deliver Comprehensive Primary Health Care is the support from health promotion staff to develop the plan and then perhaps, an extra set of hands when I’m on the ground running a program or meeting with someone about policy or workplace health promotion and that person is now always available. Management always makes it a priority to support that.* (ID08)

*I can see that the team sometimes could do things better if they could have access to little things. It might be a vehicle, sometimes it might be money to buy something that’s needed for a workshop. The location I work in works really well because we just have a card system to go to the shop, but in other more remote locations it does not work like that. We need to make sure all team members in all locations have access to physical resources where needed.* (ID01)

**Plans and reporting**

The development of individual discipline-specific health promotion action plans which specify how each team member can conduct health promotion in their
everyday practice, together with appropriate reporting processes, were identified by participants as key enablers of ability to conduct CPHC:

*I think the health promotion action plans have really made the big difference. The plans gives people direction and we’re also able to monitor what’s going on in the communities. Now [CPHC] is part of what we do, it’s just the way that we operate in our plans, in our reporting and in our daily practice.* (ID06)

**Recruitment process**

Having a recruitment process that identifies the extent to which personal values and principles align with the CPHC approach was seen as a key enabler for participants’ ability to implement CPHC:

*I would say the interview process is the most unifying aspect of the organisation. They knew who they were looking for and didn’t settle for less and the questions were fantastic because they already alerted me to what I was walking into and checked where I stood on [CPHC].* (ID13)

### 4.2.1.1.2 Direction and support for staff in CPHC

At the pre time point, the mean response for the indicator ‘Direction and support for staff in CPHC’ was 2.0 (SD=0.5), placing it in the *Proactive* category. At the interim time point, the mean response was 2.8 (SD=0.4), which was in the *High Performing* category. At the post time point, the mean response was 2.7 (SD=0.5) which was also in the *High Performing* category.

The difference between the mean scores was 0.8 (95% CI 0.4-1.8) between pre and interim time points; 0.2 (95% CI -0.6-0.2) between the interim and post time points; and 0.7 (95% CI 0.1-1.2) between pre and post time points. Participants reported significantly higher scores at the interim time point compared to the pre time point ($t$(19 degrees of freedom)$=4.272$, $p=0.000$, $d=1.9$) and significantly higher scores at the post time point compared to the pre time point ($t$(15 df)$=2.657$, $p=0.018$, $d=1.3$) (Figure 12). There was no significant difference between scores at the interim and post time points ($t$(20 df)$=0.963$, $p=0.347$).
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Figure 12: Mean scores for Comprehensive Primary Health Care Indicator ‘Direction and support for staff in CPHC’ at pre, interim and post time points

Note: *** Significant difference between pre and interim time point scores (p<0.001)
Independent Samples t test. * Significant difference between pre and post time point scores (p<0.05) Independent Samples t test

In the post program interviews, participants reported a positive impact on direction and support provided to deliver CPHC over the 12-month time period. Four key enabling factors were identified: level of CPHC knowledge; understanding how to apply CPHC in practice; whole-of-team CPHC reflective opportunities; and the nature of the Health Promotion Practitioner’s role.

**Level of CPHC knowledge**

Increasing levels of knowledge about CPHC philosophy and theory were identified as a critical enabler to provide direction and support in CPHC. Participants highlighted the value of regular CPHC training and planning days, information sessions, CPHC-focused meetings and informative emails:

*I think probably the most positive thing was having the team develop a full understanding of what Comprehensive Primary Health Care is and what it involves, because without that knowledge you can’t deliver it. I got that from the training and planning days. (ID07)*

*Previously we looked at statistics in general practice. Now we have been shown through various seminars and team day that there are changes required in [CPHC] and this information is stemming down from management. Having a Cape York Manager in Primary Health Care installed on our program to facilitate changes has really identified what needs to be changed and done and what our direction is as*
opposed to seeing people and patients all the time. We have actually had a clear
definition what [CPHC] stands for and how changes in this approach occur. (ID06)

Understanding how to apply CPHC theory in practice
Using a visual model that depicts the full continuum of CPHC in key planning
and reporting templates was identified as a key enabler of understanding how
CPHC theory can be applied in everyday practice. Participants identified being
able to visualise where their daily practice fitted along the CPHC continuum was
helpful because it enabled them to ‘see’ and assess their overall CPHC
approach. Across the CPHC continuum participants were able to identify areas
of positive work, gaps in practice and opportunities for improvement:

Having the visual was a great prompt and reminder about how we can achieve
CPHC in our daily practice. (ID10)

We have reporting templates to prompt us to continually think about
Comprehensive Primary Health Care and what fits in where. So it’s a constant
reinforcement of what it is and how we work within it. (ID11)

Participants also identified understanding the link between CPHC theory and
health promotion strategy as an important enabler. Understanding CPHC as an
overall service delivery model, then developing health promotion action plans
based on the Ottawa Charter for Health Promotion strategy areas, enabled
participants to understand how CPHC philosophy could be applied in their
everyday practice:

The knowledge of the processes and how to put it [CPHC] into play through the
Ottawa Charter for Health Promotion has been very good. (ID06)

Whole-of-team CPHC reflective opportunities
Having whole-of-team CPHC reflective opportunities was identified as an
important enabler to provide direction and support for CPHC. Participants found
using a reflective framework to guide team discussions, based on questions
about features working effectively and those in need of improvement assisted
the creation of a unified CPHC approach. Participants also found this reflection
process helped individual team members develop a better understanding of
how the team functioned as a unit to deliver more coordinated patient-centered
care:
Direction and support in CPHC has increased. That’s probably through having more reflection about what’s happening on the ground, reporting more across the scope of CPHC and the whole team recognising what falls under which area of the CPHC continuum. (ID05)

Throughout the 12 months of the reorientation, I can see how powerful and strong the team is on the ground now that we’re working in a Comprehensive Primary Health Care way. The team has actually changed over the 12 months. People are thinking about what’s happening on the ground – ‘Why am I doing what I’m doing?’ Rather than, ‘I’m doing this because it seems right’, I’m actually doing this because it’s based on these theories and it’s in a plan and heaps more structured and that’s actually working really well on the ground as well. I’ve noticed a lot of community people actually feel stronger about us on the ground than they did 12 months ago too. (ID01)

Nature of health promotion practitioner’s role
Changing the nature of the Health Promotion Practitioner’s role was highlighted as a useful way to increase direction and support for CPHC. Participants found Health Promotion Practitioner roles more useful when they acted as team coordinators for the planning, implementation and evaluation of discipline-specific health promotion plans, rather than implementing independent health promotion ‘activities’ disconnected from an overall needs assessment and planning process. Participants identified that when Health Promotion Practitioners worked in this way it enabled more accessible direction and support than was possible between management and individual team members:

We have things like the ‘Feedback Fridays’ with our Health Promotion Officers, the whole-of-team Comprehensive Primary Health Care meetings, and an opportunity to meet with management on a one-on-one basis as well whenever we feel we need. So at those points in time, we can always have confirmation about what we are doing or a query answered around Comprehensive Primary Health Care and how we can deliver it. (ID03)

It’s worked well to set aside every second Friday to have a sit-down with the Health Promotion Officers and talk about how it’s going and reflecting on the [health promotion action] plans and having that feedback opportunity with the rest of the team. (ID12)

To start with they [Health Promotion Practitioners] didn’t have a real direction, but I can see that the Primary Health Care Manager has helped them out. Now they actually play a major role in our team, in how we determine the service delivery approach. (ID10)

4.2.1.1.3 Professional development opportunities
At the pre time point, the mean response for the indicator ‘Professional development opportunities’ was 2.1 (SD=0.8), placing it in the Proactive
category. At the interim time point, the mean response was 2.7 (SD=0.4), in the *High Performing* category. At the post time point, the mean response was 2.9 (SD=0.3), also in the *High Performing* category.

The difference between the mean scores was 0.6 (95% CI -0.0-1.2) between pre and interim time points; 0.2 (95% CI -0.2-0.6) between the interim and post time points; and 0.8 (95% CI 0.1-1.5) between pre and post time points. Participants reported significantly higher scores at the post time point compared to the pre time point (t(9.0 df)=2.423, p=0.039, d=1.3) (Figure 13). There was no significant difference between scores at the pre and interim time points (t(19 df)=1.990, p=0.061) or scores at the interim and post time points (t(20 df)=1.33, p=0.271).

![Figure 13: Mean scores for Comprehensive Primary Health Care Indicator 'Professional Development Opportunities' at pre, interim and post time points](image)

* Significant difference between pre and post time point scores (p<0.05) Independent Samples t test

In the post-program interviews, participants reported a positive impact on CPHC-focused professional development opportunities in CPHC over the 12-month period. Two key enabling factors were identified: whole-of-team CPHC-focused learning opportunities; and creating a supportive culture of ongoing formal and informal CPHC-focused professional development opportunities.
Whole-of-team focused learning opportunities
Whole-of-team professional development opportunities were identified as a positive approach for team learning. Allocating dedicated time for all disciplines to meet, learn about and reflect on how CPHC can be achieved was highlighted as an effective strategy to support CPHC professional development opportunities:

*We have our training days and planning days which is professional development that's ongoing whole-of-team stuff. I have found them really good because then you feel you've got this ongoing learning curve, rather than going off to a conference for three days or a week once a year. We all work slightly differently in what we do, but to learn from psychologists about the way to speak to someone about something or how to broach something more appropriately is good.* (ID09)

Creating a supportive culture for informal professional development opportunities
In addition to creating formal professional development opportunities, participants identified it was equally important to create a culture that supports ongoing informal professional development. Informal discussions about CPHC in the lunch room, whilst driving between communities or via internal emails were highlighted as important day-to-day learning and development opportunities supplementing formal professional development sessions. Participants also identified encouragement from management to present at CPHC-related conferences as important:

*Informal meetings as well as our structured team planning days and meetings have been good too. Sometimes they happen in the lunchroom. And then in the car as a team we’ll often talk about what we’ve done that day on the way back from places - what went well, what didn’t work, what we could do differently. It’s on the spot, it’s still fresh and you can reflect on that later, after the conversation, as well.* (ID03)

*Managers encourage and support us to put in submissions to present at conferences and things like that. That has been good to consider presenting the work we do. I would not normally think about doing that and it makes me feel valued by management.* (ID11)

Identifying training needs during the recruitment and performance appraisal process
Participants highlighted the importance of identifying and supporting individual training needs during the recruitment and performance appraisal process. The
need to do this more consistently across the organisation was highlighted as a way to ensure professional development was relevant and specific to individual training needs. This would enable both individual and team needs to be addressed more adequately:

*I think you can see from the interview where staff might have some lack in skills. This is where we should identify some training needs and follow through. I don’t think the organisation is really doing that. There have been some really good examples of where they are supporting people with professional development—like the Community Engagement Officer for instance. They took her on without any health background and she’s in that health promotion course and there is support for her in that and they’re providing all that intensive support around assignments and that and that can only benefit the organisation. But, yeah, still a long way to go, I think it could be improved.* (ID01)

### 4.2.1.1.4 CPHC duties and accountabilities in job description

At the pre time point, the mean response for the indicator ‘CPHC duties and accountabilities in job description’ was 1.3 (SD=0.4), placing it in the *Reactive* category. At the interim time point, the mean response was 2.6 (SD=0.7), in the *High Performing* category. At the post time point, the mean response was 2.8 (SD=0.4), also in the *High Performing* category.

The difference between sample mean scores was 1.3 (95% CI 0.8-1.9) between pre and interim time points; 0.2 (95% CI -0.3-0.7) between the interim and post time points; and 1.5 (95% CI 1.1-2.0) between pre and post time points. Participants reported significantly higher scores at the interim time point compared to the pre time point (*t*(18 degrees of freedom)=4.893, *p*=0.000, *d*=2.4) and significantly higher scores at the post time point compared to the pre time point (*t*(15 df)=6.966, *p*=0.000, *d*=3.4) (Figure 14). There was no significant difference between scores at the interim and post time points (*t*(19 df)=0.756, *p*=0.459).
In the post-program interviews, participants reported a positive impact on CPHC duties and accountabilities in job descriptions over the 12-month period. It was highlighted that duties and accountabilities had been changed from generic clinical roles to reflect the broader determinants of health described in CPHC philosophy. It was also highlighted that changes had been made to the interview and performance appraisal process to align CPHC accountabilities with job descriptions:

*When I first started, my JD (job description) didn’t reflect [CPHC]. It just had a clinical focus. It didn’t really talk much about the broader determinants of health or working. It had more of an inward focus, then as time went on we were asked to re-write our JDs to reflect CPHC. Now my JD looks at how I will get input from external organisations, how I will work more with partners, how I will focus more on prevention and looking at the broader determinants of health, not just patient-oriented. (ID08)*

*Job descriptions have been changed to reflect how each discipline can achieve CPHC. Comprehensive Primary Health Care duties and accountabilities are now part of our job descriptions, interview panel questions and performance appraisals. (ID04)*

4.2.1.1.5 Performance indicators incorporate CPHC

At the pre time point, the mean response for the indicator ‘Performance indicators incorporate CPHC’ was 1.4 (SD=0.5), placing it in the *Reactive*
category. At the interim time point, the mean response was 2.8 (SD=0.4), in the High Performing category. At the post time point, the mean response was 2.7 (SD=0.5), also in the High Performing category.

The difference between the mean scores was 1.4 (95% CI 0.9-1.9) between pre and interim time points; 0.1 (95% CI -0.6-0.3) between the interim and post time points; and 1.3 (95% CI 0.6-1.9) between pre and post time points. Participants reported significantly higher scores at the interim time point compared to the pre time point (t(13 degrees of freedom)=5.508, p=0.000, d=2.7) and significantly higher scores at the post time point compared to the pre time point (t(12 df)=4.398, p=0.001, d=2.2) (Figure 15). There was no significant difference between scores at the interim and post time points (t(17 df)=0.631, p=0.537).

Figure 15: Mean scores for Comprehensive Primary Health Care Indicator 'Performance indicators incorporate Comprehensive Primary Health Care' at pre, interim and post time points
Note: *** Significant differences between pre and interim time point scores and pre and post time point scores (p<0.001) Independent Samples t test.

In the post-program interviews, participants reported a positive change in performance indicators incorporating CPHC over the 12-month period. Participants identified that performance indicators in job descriptions and program guidelines had changed from being generic and clinical to CPHC specific. Two enabling factors were identified to support this process:
Involvement in re-redeveloping performance indicators to incorporate CPHC; and dedicated reflection time to support the re-development process.

*Involvement in re-developing performance indicators to incorporate CPHC*

Participants identified that it was valuable for them to drive discipline-specific changes related to performance indicators to incorporate CPHC. They found being involved in the change process increased understanding of the purpose of the changes, resulting in participants feeling more connected to the change:

> The change is absolutely huge because we had the opportunity to rewrite our performance indicators and accountabilities ourselves. So we understand how our specific discipline needs to achieve CPHC and how health promotion helps us do that through Ottawa Charter action areas. (ID08)

*Dedicated reflection time to support the change process*

Participants identified dedicated whole-of-team reflection time as important to support the performance indicator change process. It was highlighted that whole-of-team reflection time allowed all disciplines to discuss how to make relevant and meaningful changes and understand how the whole team could function to achieve CPHC:

> We understand what our performance indicators are and why they include CPHC. It is from that reflection sort of stuff. Looking over our practices and then altering them depending on what we have and haven’t done and what worked and what hasn’t worked. Also reflecting as a whole team and getting how the whole team aligns with CPHC has been very good. (ID10)

**4.2.1.6 Summary of results for research sub-question one**

Research sub-question one asked: What is the impact of a CPHC ODS on FNQRDGP’s workforce development processes? From the pre to post time points, all five of the indicators of workforce development had statistically significant increases, with large to very large effect sizes, indicating movement in a positive direction towards increasing FNQRDGP’s capacity to deliver CPHC (Table 16).

Of the three *Opportunities* sub-component indicators, one shifted from *Reactive* to *High Performing* and two from *Proactive* to *High Performing*. Within the *Task...*
requirements sub-component, both indicators shifted from Reactive to High Performing.

Key enablers identified as being necessary to increase FNQRDGP’s capacity to deliver CPHC were: 1) characteristics of managers; 2) health promotion resources (human and physical); 3) whole of team CPHC-focused professional development opportunities; 4) development of discipline-specific health promotion action plans and reporting templates; 5) involvement in redeveloping discipline-specific performance indicators to incorporate CPHC; and 6) dedicated reflection time to support the application of CPHC knowledge into practice.

Table 16: Research sub-question one quantitative results summary

<table>
<thead>
<tr>
<th>CPHC ODS Component</th>
<th>CPHC ODS sub component</th>
<th>Indicators</th>
<th>t</th>
<th>p</th>
<th>d*</th>
<th>Categorial change*</th>
</tr>
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<tbody>
<tr>
<td>Workforce development Opportunities</td>
<td>1. Staff able/ supported to conduct CPHC</td>
<td>3.402</td>
<td>0.004</td>
<td>1.7(L)</td>
<td>R-HP</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Direction and support for staff in CPHC</td>
<td>2.657</td>
<td>0.018</td>
<td>1.3 (L)</td>
<td>P-HP</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Professional development opportunities</td>
<td>2.423</td>
<td>0.039</td>
<td>1.3 (L)</td>
<td>P-HP</td>
<td></td>
</tr>
<tr>
<td>Task Requirements</td>
<td>4. CPHC Duties and accountabilities in job description</td>
<td>6.966</td>
<td>0.000</td>
<td>3.4 (VL)</td>
<td>R-HP</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. Performance indicators incorporate CPHC</td>
<td>4.398</td>
<td>0.001</td>
<td>2.2 (VL)</td>
<td>R-HP</td>
<td></td>
</tr>
</tbody>
</table>

* L=large, VL=very large  
** R-P = mean score for indicator changed from Reactive category to Proactive category, P-HP = Proactive category to High Performing category, R-HP = Reactive category to High Performing category

4.2.1.2 Research sub-question two results

Research sub-question two asked: What is the impact of a CPHC ODS on FNQRDGP’s Organisational processes? Impact on organisational processes was assessed against 20 CPHC indicators (Refer to Appendix 10). Results for each indicator are described below.

4.2.1.2.1 Communication direction

At the pre time point, the mean response for the indicator ‘Communication direction’ was 2.0 (SD=0.9), placing it in the Proactive category. At the interim time point, the mean response was 2.5 (SD=0.7), in the High Performing
category. At the post time point, the mean response was 2.6 (SD=0.7), also in the *High Performing* category.

The difference between the mean scores was 0.5 (95% CI -0.3-1.2) between pre and interim time points; 0.1 (95% CI -0.5-0.7) between the interim and post time points; and 0.6 (95% CI -0.3-1.4) between pre and post time points. There were no significant differences between participants’ scores reported at the three time points: pre time point compared to the interim time point (*t*(19 degrees of freedom)=1.336, *p*=0.197); interim time point compared to the post time point (*t*(20 df)=0.315, *p*=0.756); pre time point compared to post time point (*t*(15 df)=1.385, *p*=0.186).

In the post-program interviews, participants reported a positive impact on the direction of communication over the 12-month period. A consistent communication direction and style between all levels of the organisation was highlighted as important for overall improvement. Participants described different communication styles between their direct line manager and senior managers which impacted the perception of communication within the organisation:

> It’s improving, but it’s not there yet. It’s continual from line our manager, but not from above. In terms of high management, I’d say it’s sporadic. It’s almost like withholding information when it seems suitable to them. It seems to be when it’s convenient and a choice of what to share and what not to share. That’s through the experience of people and me hearing things about changes to the organisation from other people and other organisations, not even our own organisation. That’s just a pretty bad experience. (ID01)

> I don’t think that we had really solid communication pathways at first. They certainly listened to us but it was just a bit sporadic, whereas now they’re really working on addressing things straight-away and communicating initially. (ID12)

> We had a lot of incidents where it was just staff going to their line manager and then their line manager not reporting back to senior management and that’s changed now to be multi-directional. (ID04)

### 4.2.1.2 Reference to CPHC in policies

At the pre time point, the mean response for the indicator ‘Reference to CPHC in policies’ was 1.6 (SD=0.8), placing it in the *Reactive* category. At the interim time point, the mean response was 2.7 (SD=0.5), in the *High Performing*
category. At the post time point, the mean response was 2.8 (SD=0.4), also in the High Performing category.

The difference between the mean scores was 1.2 (95% CI 0.5-1.8) between pre and interim time points; 0.1 (95% CI -0.4-0.5) between the interim and post time points; and 1.2 (95% CI 0.5-1.9) between pre and post time points. Participants reported significantly higher scores at the interim time point compared to the pre time point (t(16 degrees of freedom)=3.938, p=0.001, d=1.9) and significantly higher scores at the post time point compared to the pre time point (t(14 df)=3.902, p=0.002, d=2.0) (Figure 16). There was no significant difference between scores at the interim and post time points (t(18 df)=0.247, p=0.808).

![Figure 16: Mean scores for Comprehensive Primary Health Care Indicator 'Reference to Comprehensive Primary Health Care in policies' at pre, interim and post time points](image)

**Note:** *** Significant difference between pre and interim time point scores (p<0.001) Independent Samples t test. ** Significant difference between pre and post time point scores (p<0.01) Independent Samples t test.

In the post-program interviews, participants reported a positive impact on the reference to CPHC in policies over the 12-month period. Participants identified the increase in health promotion planning and reporting across the full CPHC continuum as important policy changes. Some participants made a distinction between changes made at the team planning and reporting level from formal policies endorsed by senior management:
Policy changes or suggestions on time we spend clinically versus health promotion helped broaden the extent of change required for me. Policy changes in that having an Action Plan for communities has helped me in realise what needs to be done. (ID07)

When we did this 12 months ago, it was probably more like the processes were just beginning to be in place but now they’re rolling ahead. So that probably has increased in my mind. The action plans give us, in writing, what our job entails and where we are to go, so it gives us goals. (ID05)

I think when I first came on board we had nothing. Now it is consistent planning, with the Primary Health Care Manager mainly leading it. It’s a real area that we need to be supported by senior management. Some of those policies and procedures should be built around indigenous values and beliefs. If you really want to make change out in Indigenous communities you’ve got to take that into account, I don’t think senior management are doing that. (ID13)

4.2.1.2.3 Support for health promotion program planning

At the pre time point, the mean response for the indicator ‘Support for health promotion program planning’ was 1.71 (SD=1.0), placing it in the Proactive category. At the interim time point, the mean response was 3.00 (SD=0.0), in the High Performing category. At the post time point, the mean response was 2.67 (SD=0.7), also in the High Performing category.

The difference between the mean scores was 1.3 (95% CI 0.4-2.2) between pre and interim time points; 0.4 (95% CI -1.0-0.1) between the interim and post time points; and 0.8 (95% CI -0.1-1.7) between pre and post time points. Participants reported significantly higher scores at the interim time point compared to the pre time point (t(6.0 degrees of freedom)=3.576, p=0.12, d=2.7) (Figure 17). There was no significant difference between scores reported at the interim and post time points (t(8.0 df)=0.1835, p=0.104) or the pre and post time points (t(14 df)=2.011, p=0.064).
In the post-program interviews, participants reported a positive impact on support for health promotion program planning over the 12-month period. Two key enabling factors were identified: specific health promotion roles with in-depth health promotion knowledge; and health promotion role and planning integrated within and across teams.

**Specific health promotion roles with in-depth health promotion knowledge**

Participants identified that it was important to have health promotion practitioner roles on the team with the specific skill set that could support a range of health professionals to undertake health promotion program planning:

*Having a health promotion officer there is great, to help you look at your goals, how you’re going to achieve them and how they fit in within the organisation’s mission and objectives. Without them it would be pretty hard, especially when it’s not your primary thing. (ID07)*

*We’ve got several people supporting us within the organisation and their health promotion knowledge is extensive. I’m learning and my planning’s done with the help of other people, with specific skills in health promotion. (ID09)*

*With this health promotion program planning, we have an abundance of knowledge about health promotion. There’s a few people with in-depth knowledge which is good. (ID12)*
Before health promotion was not defined, what their [Health Promotion Officer] roles were, how they can contribute to the team. So then you do get limited support because you don’t know what it is. But because it has been explained, our knowledge has grown a lot more about how they can help; there's been a lot more support for that. (ID03)

Health promotion role and planning integrated within and across teams

Having health promotion practitioners to facilitate integrated planning within and across teams was identified as a key enabler to support health promotion planning:

When I first started staff were just doing what they thought needed to happen. But we didn't really support that link between different health promotion activities. So I think now a great example is the health promotion practitioners being teamed up to work with the allied health staff and the two teams to work with each other, to have different components of their areas in which they work with for them to merge together. (ID10)

I think health promotion is now definitely integrated, it’s in everyone’s program that everyone works towards it and it’s definitely well established. In terms of the team, they are getting inspired to do health promotion or have that approach in their plans and stuff and they understand it a lot more. (ID11)

4.2.1.2.4 Whole-of-team meetings inclusion of CPHC and health promotion

At the pre time point, the mean response for the indicator ‘Whole-of-team meetings inclusion of CPHC and health promotion’ was 1.7 (SD=0.5), placing it in the Proactive category. At the interim time point, the mean response was 2.5 (SD=0.5), in the High Performing category. At the post time point, the mean response was 2.7 (SD=0.5), also in the High Performing category.

The difference between the mean scores was 0.7 (95% CI 0.2-1.3) between pre and interim time points; 0.2 (95% CI -0.3-0.7) between the interim and post time points; and 1.0 (95% CI 0.4-1.5) between pre and post time points. Participants reported significantly higher scores at the interim time point compared to the pre time point (t(16 degrees of freedom)=3.004, p=0.008, d=1.5) and significantly higher scores at the post time point compared to the pre time point (t(14 df)=3.819, p=0.002, d=2.2) (Figure 18). There was no significant difference between scores at the interim and post time points (t(18 df)=0.921, p=0.369).
Figure 18: Mean scores for Comprehensive Primary Health Care Indicator 'Whole-of-team meetings inclusion of Comprehensive Primary Health Care and health promotion' at pre, interim and post time points.

Note: ** Significant differences between pre and interim time point scores and pre and post time point scores (p<0.01) Independent Samples t test.

In the post-program interviews, participants reported a positive impact on whole-of-team meetings inclusion of CPHC and health promotion over the 12-month period. Participants identified two factors about team meetings that were useful to build capacity to deliver CPHC: regular meetings in a range of formats; and dedicated time to reflect and evaluate team actions across CPHC continuum.

**Regular meetings in a range of formats**

Participants identified a range of meetings in varied formats that included CPHC and health promotion. Whole-of-team meetings, discipline-specific meetings, travel team meetings and ‘Feedback Friday’ meetings\(^1\) with Health Promotion Practitioners were all identified as including CPHC and health promotion:

*When I first came on board the teams used to meet every Friday, but around health promotion there was nothing. Now we’re having regular team meetings. So they’re regular now and they’ve got a real high promotion focus.* (ID04)

*The meetings are consistent and helpful to the team. I think we’ve had three whole team CPHC training meetings this year, we also had CPHC planning days and*

\(^1\) ‘Feedback Friday’ meetings were dedicated time that the Health Promotion Practitioners met with team members to reflect on progress against health promotion action plans.
there has been fortnightly ‘Feedback Fridays’ with our Health Promotion Practitioners. We also talk about it with our team when we are travelling on the plane and in the car. So meetings have been consistent and helpful for the team. (ID09)

**Dedicated time to reflect and evaluate team actions across the CPHC continuum**

Participants identified that it was useful to evaluate progress against the CPHC continuum in whole-of-team meetings as it enabled team members to benchmark CPHC activities and identify opportunities for improvement:

> A lot of CPHC and health promotion is based around feedback. So in our team meetings we get to evaluate where we are and where we need to go to continue on with new stuff. So that’s our ‘Feedback Friday’ meetings and all that sort of stuff, specific towards those areas that we need to improve. (ID11)

**4.2.1.2.5 Type of quality improvement within programs**

At the pre time point, the mean response for the indicator ‘Type of quality improvement within programs’ was 1.1 (SD=0.4), placing it in the Reactive category. At the interim time point, the mean response was 2.4 (SD=0.7), in the High Performing category. At the post time point, the mean response was 2.6 (SD=0.7), also in the High Performing category.

The difference between the mean scores was 1.3 (95% CI 0.7-1.8) between pre and interim time points; 0.1 (95% CI -0.5-0.8) between the interim and post time points; and 1.4 (95% CI 0.8-2.1) between pre and post time points. Participants reported significantly higher scores at the interim time point compared to the pre time point (t(17 degrees of freedom)=5.305, p=0.000, \(d=2.4\)) and significantly higher scores at the post time point compared to the pre time point (t(14 df)=4.654, p=0.000, \(d=2.4\)) (Figure 19). There was no significant difference between scores at the interim and post time points (t(19 df)=0.454, p=0.655).
In the post-program interviews, participants reported a positive impact on the type of quality improvement within programs over the 12-month period. Five key enabling factors were identified: management driven and supported; understanding how the Indigenous Community Development Liaison Officer role supports quality improvement; clear health promotion program guidelines; inclusion of a partnership strategy in discipline-specific health promotion action plans; and formalised organisational policies based on community feedback.

Management driven and supported

Participants identified it was important for quality improvement processes to be driven and supported by management. It was highlighted that when management drive and support a quality improvement process it becomes part of the organisation’s culture and individual staff start thinking in terms of continuous quality improvement:

*I think initially maybe we had our blinkers on as an organisation. Now it's really clear that the division is focused on improvement and taking or getting external feedback and actually doing it formally, looking at QI [quality improvement] in a structured way.* (ID02)

Managers are really focused on improving our practice and improving the organisation in every aspect. It's become more of the way that we operate and
think now. We think in terms of continuous quality improvement whereas maybe before it wasn’t even spoken about that much. (ID01)

Management are really encouraging more improvement into the services, for example, through the [health promotion] action plans and policies and procedures, training, and continual improvement in their training etc. (ID06)

Understanding how the Indigenous Community Development Liaison Officer’s role supports quality improvement
Greater understanding of how the Indigenous Community Development Liaison Officer role supported engagement between the community and the team was identified as a key enabler for quality improvement within programs. The Indigenous Community Development Liaison Officers highlighted positive changes in quality improvement processes within programs when the non-Indigenous staff improved understanding of the Officers’ links to community and how these links could maximise understanding of community wants and needs:

A lot of the contact on the ground or at the community level didn’t come through, didn’t feed through to the organisation in the beginning stages. And it’s slowly started. I suppose there wasn’t a lot of understanding about my role [Indigenous Community Development Liaison Officer] and how the team could work with it. We had to work out exactly what it was and I think working that out has increased [communication] between the community and the team. Just the establishment of my role probably helped and just the understanding of it probably helped I think – helped with community feedback. So the team understands why we’re here and I think you do get quite a lot of community feedback through us [Indigenous Community Development Liaison Officer roles]. Community are probably a lot more open too, I suppose giving us information about their needs to take to the organisation. And that’s continuous really - finding out what we’re here for, how much we can do. (ID10)

Clear health promotion program guidelines
Having clear health promotion program guidelines and health promotion roles to support the team apply the guidelines were identified as a key enabler to support quality improvement within programs:

What the organisation has done with the health promotion position has improved quality improvement within programs, as well as an understanding of those processes with [health promotion] planning. I wouldn’t have known those sorts of things. There wasn’t a clear process to organise a [health promotion] program before. There’s a checklist of things that we need to do now before a program can start to make sure we have engaged with the community and the program is based on community needs. (ID13)

We’re assessing things and constantly doing evaluation after every [health promotion] activity with our Health Promotion Practitioners. That’s going to be looked at further, evaluating constantly. (ID12)
4.2.1.2.6 Reflection on program goal and objectives aligned with CPHC principles

At the pre time point, the mean response for the indicator ‘Reflection on program goal and objectives aligned with CPHC principles’ was 1.3 (SD=0.5), placing it in the Reactive category. At the interim time point, the mean response was 2.6 (SD=0.7), in the High Performing category. At the post time point, the mean response was 2.8 (SD=0.4), also in the High Performing category.

The difference between the mean scores was 1.3 (95% CI 0.7-1.9) between pre and interim time points; 0.2 (95% CI -0.3-0.7) between the interim and post time points; and 1.5 (95% CI 1.0-2.0) between pre and post time points. Participants reported significantly higher scores at the interim time point compared to the pre time point (t(17 degrees of freedom)=4.466, p=0.000, d=2.2) and significantly higher scores at the post time point compared to the pre time point (t(14 df)=6.413, p=0.000, d=3.2) (Figure 20). There was no significant difference between scores at the interim and post time points (t(19 df)=0.756, p=0.459).

![Figure 20: Mean scores for Comprehensive Primary Health Care Indicator 'Reflection on program goals and objectives aligned with Comprehensive Primary Health Care principles' at pre, interim and post time points](image)

Note: *** Significant differences between pre and interim time point scores and pre and post time point scores (p<0.001) Independent Samples t test.
In the post-program interviews, participants reported a positive impact on the reflection on program goals and objectives aligned with CPHC principles over the 12-month period. Two key enabling factors were identified: frequency of reflection; and the nature of reflection.

**Frequency of reflection**

Participants highlighted it was important to have regular opportunities to reflect on how program goals and objectives align with CPHC principles. It was identified that having more opportunities to reflect contributed to achieving CPHC outcomes:

*Through the ‘Feedback Friday’ time we look at the action plan and what we’ve achieved and what we haven’t achieved and why, reflecting constantly. It’s important that we’re doing that regularly to keep us on track with outcomes.* (ID07)

*We’ve been asked to meet fortnightly with our Health Promotion Practitioners to catch up on how we are progressing and how they can help us so I have felt that things are moving further along to achieve our goals.* (ID08)

**Nature of reflection**

It was identified that the nature of reflection was important when reflecting on CPHC program goal and objectives. Participants found reflection focus broadened from clinically quantitative to more holistically qualitative. Participants felt this broader style of reflection helped them understand that they were working towards achieving CPHC program goals and objectives both inside and outside the clinical setting. For example, participants’ realised casual conversations were valuable and relevant to achieving CPHC program goals and objectives:

*It’s how we look at things. Rather than just recording and reporting on individual clinical things, looking at everything we do. Like you might have chat to someone on a plane or you might talk to someone in the community; all those things are part of your job rather than thinking your job is just your clinical hours. It’s freeing in a sense, thinking that it’s beyond just, ‘How many clients did I see today?’ or even, ‘How many education sessions did I do today?’ The fact that the comprehensive thing. It’s not just about fronting up to a clinic and bugging off. And I think we’ve all been encouraged to look on it that way. It’s also the work we do after-hours outside of the clinic; it’s part of the whole process.* (ID03)

*Initially our goals and outcomes were probably more numbers-focused - how many people attended a group, how many people were seen in the clinic - whereas now*
it’s got more of a long term focus and more of a qualitative focus, a qualitative and holistic focus. (ID06)

Having CPHC and health promotion incorporated into our reports is actually more reflective of what is going on and what’s happening on the ground. Whereas without that, it was more like 500 one-on-one consultations and then maybe six health promotional activities where about 42 people turn up... It's more being able to reflect on and actually measure outcomes and measure people’s behaviour. It’s more behavioural and what people want to change, whereas before it was very cut and dry. (ID02)

4.2.1.2.7 Process for determining program priorities

At the pre time point, the mean response for the indicator ‘Process for determining program priorities’ was 1.7 (SD=0.5), placing it in the Proactive category. At the interim time point, the mean response was 2.7 (SD=0.5), in the High Performing category. At the post time point, the mean response was 2.8 (SD=0.4), also in the High Performing category.

The difference between the mean scores was 0.9 (95% CI 0.4-1.4) between pre and interim time points; 0.1 (95% CI -0.3-0.6) between the interim and post time points; and 1.1 (95% CI 0.6-1.6) between pre and post time points. Participants reported significantly higher scores at the interim time point compared to the pre time point (t(16 degrees of freedom)=3.827, p=0.001, d=2.1) and significantly higher scores at the post time point compared to the pre time point (t(14)=4.571, p=0.000, d=2.3) (Figure 21). There was no significant difference between scores at the interim and post time points (t(18)=0.659, p=0.518).
In the post-program interviews, participants reported a positive impact on the process for determining program priorities over the 12-month period. Three key enabling factors were identified: management support to work with community-identified priorities; understanding different types of community engagement processes; and increasing awareness about how CPHC-focused health professionals can work with communities to determine priorities. Guidelines and deliverables attached to program funding were identified as key challenges that impact negatively on participants’ processes for determining program priorities.

Management support to work with community-identified priorities

Having management support to work with community-identified priorities was highlighted as a key enabler in determining program priorities. Participants’ found management support made it possible to work with the community’s agenda:

*Now we’re supported to work with the community more in finding out what they want and what’s important to them and we have the flexibility in being able to meet that. We don’t come in with our own agenda. (ID05)*

Understanding different types of community engagement processes

Figure 21: Mean scores for Comprehensive Primary Health Care Indicator ‘Process for determining program priorities’ at pre, interim and post time points

Note: *** Significant differences between pre and interim time point scores and pre and post time point scores (p<0.001) Independent Samples t test.
Understanding different types of community engagement processes was identified as a key enabler in determining program priorities. Participants' recognised differentiation between processes which simply 'involve' the community compared to those that are 'community-driven' was critical to inform and understand how priorities were being determined:

We can't just say, 'Oh, community involvement is important'. Community must drive initiatives - they develop them, they design them. Anything that we put down on paper really has to be the community's ideas. It just has to be, otherwise it won't work. (ID08)

**Increasing awareness about how CPHC-focused health professionals can work with communities to determine priorities**

Increasing awareness about how CPHC-focused health professionals can work with communities to determine priorities was identified as a key enabler. Participants' identified the importance of viewing themselves as 'change agents' rather than 'health experts'. This enabled them to learn from the community about how their skills and services could be maximised to support changes in community-determined needs. In order to understand and work as 'change agents', leadership traits were identified as desirable qualities for all team members:

We have learnt that we're advocates for change. We're in the community to encourage people to take control and ownership over what's important to them. Why would people change if they didn't even know what they were supposedly needing to address? Take nutrition for example, if they don't know that it's even an issue or it's even leading to poor health in the community, why would they do anything about it? So if we can be on the ground and constantly learn about what they would like changed and what can be done and how we can build capacity for their needs in their culture and their society – that is wonderful. (ID09)

Leaders create opportunities for community to determine health service priorities. There's a whole heap of leaders within our team. We've got the Indigenous Community Development Liaison Officers out there doing that kind of work. We've got the Health Promotion Officers and we even have the different allied health disciplines too, out there talking with the community about what their needs are. (ID01)

**Guidelines and deliverables attached to program funding**

Guidelines and deliverables attached to program funding were identified as challenging factors which can restrict health services from learning about community-identified priorities. Participants identified that health services reliant
on external funding need to follow pre-determined guidelines and deliverables that do not necessarily align with community priorities:

*We all want to work with community needs but in practice it’s a tough thing to do when we have funding bodies telling us what we need to work on. We do have to answer to our funding deliverables so unfortunately we have to rush things and it means that we do sometimes miss that [community engagement] part. (ID13)*

*Instead of setting priorities at that senior government level, somewhere we’ve got to make the connection with the local people about what they see as their health issues, not what we or other outsiders see as their health issues. I think we can work better with communities if we do it that way. (ID01)*

**4.2.1.2.8 Reward systems for achievements in CPHC work**

At the pre time point, the mean response for the indicator ‘Reward systems for achievements in CPHC work’ was 2.0 (SD=0.6), placing it in the *Proactive* category. At the interim time point, the mean response was 2.3 (SD=0.5), also in the *Proactive* category. At the post time point, the mean response was 2.8 (SD=0.4), in the *High Performing* category.

The difference between the mean scores was 0.3 (95% CI -0.2-0.9) between pre and interim time points; 0.4 (95% CI 0.0-0.9) between the interim and post time points; and 0.8 (95% CI 0.2-1.3) between pre and post time points.

Participants reported significantly higher scores at the post time point compared to the pre time point \( t(14\text{ degrees of freedom})=3.063, p=0.008, \ d=1.5 \) and significantly higher scores at the interim time point compared to the pre time point \( t(19)=2.138, p=0.05, \ d=1.0 \) (Figure 22). There was no significant difference between scores at the pre and interim time points \( t(17\text{ df})=1.338, p=0.199 \).
In the post-program interviews, participants reported a positive impact on reward systems for achievement in CPHC work over the 12-month period. Structured performance appraisals were identified as a key enabler to recognise achievements in CPHC work. Two recommendations were made to further improve reward systems for achievements in CPHC. These included: create reward systems separate from and in addition to performance appraisals; and recognition for achievements in CPHC from senior management.

**Structured performance appraisal process**
Delivering structured performance appraisals that captured a broad range of feedback from colleagues, partner organisations and community members was identified as an effective reward system for achievements in CPHC. Participants felt valued and motivated to work towards achieving CPHC goals when recognition and acknowledgement was provided through a formal and documented performance appraisal process:

*The performance appraisal process is quite good, quite extensive. It looks at your work and it’s an honest answer and it’s not just an excellent, good, fair, poor. It’s an actual response to go with that; a rating and feedback from different members*
of the team, different levels of people that you’ve worked with on the ground. So it’s very thorough and so for me it felt like it was acknowledging my achievements. That in itself was very nice and it also gave motivation to continue putting in that extra bit of work. It’s actually nice to know you’re not inflicting change on people, but you’re bringing upon a positive change for people in the community. Hearing that is good. (ID13)

Reward systems outside of performance appraisals

Having additional reward systems established, outside of performance appraisals, was identified as an important way to recognise ongoing achievements in CPHC work. Participants highlighted continual recognition as important to embed CPHC practice in the organisation’s culture:

There’s a lot of recognition within the performance appraisals but outside of that, not really. We need more formal recognition outside of performance appraisals to know we are on track and the organisation is happy with what we are doing. Performance appraisals only happen once a year so we need more feedback from the organisation in-between times. (ID02)

We get formal recognition for our achievements in CPHC work through our performance appraisals but I think that would be because of the person filling it out and doing it. Obviously if our Primary Health Care Manager is conducting our performance appraisal we’ll get feedback that’s oriented towards what we’re doing in a community level and what we’re achieving etc. But it would be good to have a formal system or staff recognition system in place at a senior management level. This would really help to build a culture for CPHC work. (ID11)

Need for formal acknowledgment from senior management

Having formal acknowledgement from senior management was identified as a way to improve the reward systems for achievements in CPHC work. Participants highlighted verbal acknowledgement and performance appraisals from their direct line manager as important but felt there needed to also be formal acknowledgement from senior management:

Recognition is largely verbal, I’m talking to my manager about the things we’ve done, talking to HPO’s [Health Promotion Officers] about things we’ve done. But there’s no recognition from a senior organisational level. We haven’t been getting any feedback from those guys. I think it’s important to get recognition from senior management because it builds loyalty. We have pride and want to work for the division and I guess you would like to be told you have developed a good program and that they have taken the time to understand what our programs are. We do get recognition from our line manager but any higher up is very informal and stuffy in places. (ID06)

The organisation doesn’t do it well. In fact I don’t know if many organisations do it well but I think it’s something that should be really embedded in practice from a senior management level. Staff members have received feedback from their line
4.2.1.2.9 Organisational structures and systems to support health promotion
At the pre time point, the mean response for the indicator ‘Organisational structures and systems to support health promotion’ was 1.4 (SD=0.5), placing it in the Reactive category. At the interim time point, the mean response was 2.6 (SD=0.5), in the High Performing category. At the post time point, the mean response was 2.8 (SD=0.4), also in the High Performing category.

The difference between the sample mean scores was 1.2 (95% CI 0.8-1.7) between pre and interim time points; 0.2 (95% CI -0.3-0.6) between the interim and post time points; and 1.4 (95% CI 0.9-1.9) between pre and post time points. Participants reported significantly higher scores at the interim time point compared to the pre time point (t(19 degrees of freedom)=5.047, p=0.000, d=2.4) and significantly higher scores at the post time point compared to the pre time point (t(15 df)=6.037, p=0.000, d=2.9) (Figure 23). There was no significant difference between scores at the interim and post time points (t(20 df)=0.778, p=0.336).

Figure 23: Mean scores for Comprehensive Primary Health Care Indicator ‘Organisational structures and systems to support health promotion’ at pre, interim and post time points
Note: *** Significant differences between pre and interim time point scores and pre and post time point scores (p<0.001) Independent Samples t test.
In the post-program interviews, participants reported a positive impact on organisational structures and systems to support health promotion over the 12-month period. Three key enabling factors were identified: information sharing systems; team structure; and health promotion policies and procedures.

**Information sharing systems**
Establishing information sharing systems related to health promotion and CPHC were identified as a key enabler to support health promotion. Participants highlighted that sharing information about how to use the health promotion role to help achieve CPHC goals and facilitate links between CPHC philosophy and health promotion values and principles was useful:

*Not knowing what Health Promotion Officers did to what extent, I now realise that they are there to facilitate and legitimise our health promotion plans and ambitions and to give us some direction in achieving CPHC. (ID07)*

*People didn’t really know what a Health Promotion Officer was there to do, how they could help, how they could create opportunities for the team. So that was probably one of the main things to support health promotion – information was shared about how Health Promotion Officers could help us with our work. (ID09)*

*I wasn’t too sure of all of the principles that come along with health promotion. It didn’t sort of spread into the team before now. The sharing of information about health promotion principles and how it can be used to achieve CPHC has been spread across the team now. (ID12)*

**Team structure**
Establishing a team structure that supported health promotion planning, implementation and evaluation processes was identified as a key enabler supporting health promotion. Participants found having a manager with a background in health promotion helped establish a team structure conducive to health promotion support:

*I think the support for health promotion is about how the team is structured. You’ve got the Primary Health Care Manager, who has a background in health promotion, who oversees the Health Promotion Officers and the Health Promotion Officer supports us to develop health promotion action plans. This team structure supports us to do health promotion. (ID08)*

*There used to be just one designated person who incorporated health promotion into aspects of team work. Now it’s a range of structures that support health promotion activity and multiple levels of support through management and Health Promotion Officers. They support us to carry out health promotion. (ID09)*
Policies and procedures to support health promotion

Having clear policies and procedures in place was identified as a key enabler to support health promotion. Participants highlighted three specific policies and procedures that were particularly useful: acknowledging that health promotion is everyone’s business; dividing time between clinical and health promotion practice; and reporting against health promotion action plans that incorporate the Ottawa Charter for Health Promotion and the CPHC continuum:

When I first started there wasn’t much of a focus on the health promotion work, it was more of a clinical focus. Now it’s very evident that we’ve reoriented the health services over the past year. It used to be mainly the Health Promotion Officer’s role, whereas now they facilitate everyone else to work in the health promoting way. (ID07)

I talked with my manager about how I could divide my time between health promotion and clinical work. For my discipline we decided it should be 50/50 health promotion and clinical. So having a clear policy about how I should spend my time in the community definitely increased how much health promotion I do. (ID08)

Health Promotion is now very much being incorporated into all our work activities. Everything we do has a [CPHC] approach to it. (ID11)

The [health promotion] action plans seem to be making a real difference in people’s performance. When we didn’t have action plans, we weren’t really aware of what promotion of health was going on out in the community, but now just looking at the action plans you can see the directions and where they’re moving. (ID05)

We’ve got regular planning days in place, we’ve got health promotion and CPHC templates in place, we’ve got reporting structures, we’ve got the feedback days to help us report. We’re trained in CPHC and health promotion. We have our days where we write up our health promotion plans. We use the Ottawa Charter for Health Promotion and the CPHC continuum to report on our work. (ID10)

4.2.1.2.10 Health promotion human resources

At the pre time point, the mean response for the indicator ‘Health promotion human resources’ was 1.4 (SD=0.8), placing it in the Reactive category. At the interim time point, the mean response was 2.6 (SD=0.7), in the High Performing category. At the post time point, the mean response was 2.7 (SD=0.5), also in the High Performing category.

The difference between the sample mean scores was 1.2 (95% CI 0.4-1.9) between pre and interim time points; 0.1 (95% CI -0.5-0.6) between the interim and post time points; and 1.2 (95% CI 0.5-1.9) between pre and post time
points. Participants reported significantly higher scores at the interim time point compared to the pre time point ($t(17$ degrees of freedom)$=3.408$, $p=0.003$, $d=1.6$) and significantly higher scores at the post time point compared to the pre time point ($t(14$ df)$=3.845$, $p=0.002$, $d=1.9$) (Figure 24). There was no significant difference between scores at the interim and post time points ($t(19)=0.313$, $p=0.758$).

![Figure 24: Mean scores for Comprehensive Primary Health Care Indicator 'Health promotion human resources' at pre, interim and post time points](image)

Note: *** Significant differences between pre and interim time point scores and pre and post time point scores ($p<0.001$) Independent Samples $t$ test.

In the post-program interviews, participants reported a positive impact on health promotion human resources over the 12-month period. Having health promotion human resources at multiple levels within the team structure was identified as useful to reinforce support for health promotion. For example, participants noted that having Health Promotion Practitioners to support daily CPHC practice and management to develop strategic health promotion visions was an effective use of health promotion human resources in the organisation:

*I definitely feel that we do have human resources allocated to the right health promotion support. We’ve got two Health Promotion Officers and a manager with a health promotion background. Then, we’ve all had quite extensive training and support through the health promotion framework and support in developing our plans. (ID04)*
I think that over the 12 months I’ve been here they’ve put on more people who are very much into a more comprehensive approach to providing care. That sort of obviously flows on, or it’s really strongly felt at the coal face, at the level of patient care. I guess with the Primary Health Care Manager and both HPO [Health Promotion Officer] roles filled as well now, we’ve got more support to really influence everybody. They are building our capacity, they are working with us on the plans. I think that’s being supported from management level which is really creating a health promotion focus on the ground. (ID10)

4.2.1.2.11 Organisation’s approach to collaboration
At the pre time point, the mean response for the indicator ‘Organisation’s approach to collaboration’ was 2.1 (SD=0.7), placing it in the Proactive category. At the interim time point, the mean response was 2.9 (SD=0.3), in the High Performing category. At the post time point, the mean response was 2.8 (SD=0.4), also in the High Performing category.

The difference between the mean scores was 0.8 (95% CI 0.1-1.4) between pre and interim time points; 0.1 (95% CI -0.5-0.2) between the interim and post time points; and 0.6 (95% CI 0.0-1.2) between pre and post time points. Participants reported significantly higher scores at the interim time point compared to the pre time point (t(7.2 degrees of freedom)=2.826, p=0.025, d=1.6) and significantly higher scores at the post time point compared to the pre time point (t(14)=2.244, p=0.042, d=1.1) (Figure 25). There was no significant difference between scores at the interim and post time points (t(19 df)=0.873, p=0.393).
In the post-program interviews, participants reported a positive impact on the organisation’s approach to collaboration over the 12-month period. Partnering with multiple community services and organisations was highlighted as an effective approach to achieve collaboration. Improving links across different programs within the organisation was also recommended as a way to further strengthen the organisation’s approach to collaboration. Participants noted that collaboration could potentially have negative impacts on achieving CPHC goals if the organisation’s values and principles are compromised through the collaborative process.

**Partnering with multiple community services and organisations**

Maintaining multiple community partnerships was identified as an effective strategy used by the organisation to achieve collaboration:

*They’ve changed their focus on collaboration. We used to work more just as an organisation especially given that we spent a lot of time just running clinics but now we have partnership strategies written into our [health promotion] action plans and we give feedback to management about what partnerships we’re developing. I suppose the links that the division has developed over the past six-to-nine months with external organisations makes that evident. (ID13)*

*Definitely for myself and our team’s perspective, there’s always a lot of collaboration and strong partnerships formed and, definitely working with local people from that area, they’re stronger relationships to begin with, I think. The*
organisation is definitely respectful of having that local knowledge and using that wisely. (ID12)

Yeah it’s good, because we’re talking with community members, organisations within communities, education. Like we’re not just going out there and deciding, ‘Hey, we’re going to do this’. It’s all what’s needed, what support we can work with to do that. So we are definitely collaborating. (ID05)

**Internal and external collaboration**

Participants acknowledged the organisation’s approach to collaboration could be improved by working across program areas more effectively. It was identified that the organisation has clear processes for collaboration with external stakeholders but not for internal program areas:

I think that between all the different programs internally there could be more collaboration. All the Primary Health Care staff should know how many Health Action Teams we have set up because it’s an important part of community and working with a Health Action Team could benefit them. So internally, I don’t think that there is too much collaboration. Externally we are aware of meetings partnership forums etc. and that helps. (ID02)

**Negative impact of collaboration on CPHC goals**

Collaborating with organisations which do not work from the same underlying CPHC values and principles was identified as having a negative impact on achieving CPHC goals. Participants identified that through some external partnerships the organisation had to compromise their strong standing on the CPHC approach in order to collaborate productively:

It’s now about organisations working together which means ideologies are watered down because there needs to be a compromise made with the divisions of the organisations that we’re working with. You don’t just perfect your ideas and sell them to someone else, you actually have to drop your agendas, whether they’re good agendas or bad agendas, and meet in the middle in the spirit of compromise and of course a lot of stuff is compromised in a bad way as well as probably in a good way. So we’re more collaborative – but we’re also more exposed. (ID13)

We are focused on wellbeing. We’re not just looking at feet or individual body parts, we’re talking about quality of lives all the time and, of course, when you’re talking about quality of life you incorporate voluntarily the political and the structural stuff. So we need to work alongside organisations that traditionally have nothing to do with wellbeing, but we need to play ball and share a vision with people that we know don’t focus on CPHC or work in that way. (ID11)

**4.2.1.2.12 Nature of organisation’s structure**

At the pre time point, the mean response for the indicator ‘Nature of organisation’s structure’ was 1.8 (SD=0.7), placing it in the Proactive category.
At the interim time point, the mean response was 2.4 (SD=0.7), in the *High Performing* category. At the post time point, the mean response was 2.7 (SD=0.5), also in the *High Performing* category.

The difference between the mean scores was 0.6 (95% CI 0.0-1.3) between pre and interim time points; 0.3 (95% CI -0.3-0.8) between the interim and post time points; and 0.9 (95% CI 0.3-1.5) between pre and post time points. Participants reported significantly higher scores at the interim time point compared to the pre time point (t(19 degrees of freedom)=2.102, p=0.049, \(d=0.9\)) and significantly higher scores at the post time point compared to the pre time point (t(15)=3.115, p=0.007, \(d=1.5\)) (Figure 26). There was no significant difference between scores at the interim and post time points (t(20 df)=1.093, p=0.287).

![Figure 26: Mean scores for Comprehensive Primary Health Care Indicator 'Nature of organisation's structure' at pre, interim and post time points](image)

**Note:** Significant differences between pre and interim time point scores and pre and post time point scores (p<0.01) Independent Samples t test.

In the post-program interviews, participants reported a positive impact on the nature of the organisation’s structure over the 12-month period. Developing a horizontal network structure compared to a hierarchical structure was identified as having a positive impact on capacity to deliver CPHC:
When we first started it was very hierarchical and we were very much guided by Queensland Health clinic’s DON’s [Director of Nursing], things like that. Now we’ve created much more of a horizontal network. We work in heavily with the health workers. I know, in terms of health promotion, we’re doing a lot of that stuff with health workers then enhanced with their DON’s. We’re having meetings now with different community services. We’re having meetings with Queensland Health nutritionists, mental health teams, things like that. (ID05)

Creating an organisational structure with more accountability to the community was recognised as a way the organisation could improve its structure:

The organisation could improve its structure by being more accountable and reporting to the community what is going on. That may happen at a practitioner level, but at an organisational level I don’t think it does. Although there are different higher management meetings they are not accountable directly to the community. (ID01)

The nature of competitive funding applications was highlighted as having a negative impact on health services attempting to have outward collaborative structures:

It’s a competitive environment up here for funding so when most organisations get funding for stuff they think about their stuff first and then bring in the other people. There is a bit of an inward focus in terms of how resources are firstly gained and then used. Once that’s secured, then the network structure comes into it, but it’s an afterwards thing. Perhaps another funding approach would benefit services to work more collaboratively. It would be better if it was set up in a way that before getting the funding, health services have to look at what’s out there and see what sort of partnerships and collaborations you can use to leverage resources. (ID02)

4.2.1.2.13 Management style
At the pre time point, the mean response for the indicator ‘Management style’ was 1.6 (SD=0.7), placing it in the Reactive category. At the interim time point, the mean response was 2.7 (SD=0.6), in the High Performing category. At the post time point, the mean response was 2.9 (SD=0.3), also in the High Performing category.

The difference between the mean scores was 1.1 (95% CI 0.4-1.7) between pre and interim time points; 0.2 (95% CI -0.3-0.7) between the interim and post time points; and 1.3 (95% CI 0.6-1.9) between pre and post time points. Participants reported significantly higher scores at the interim time point compared to the pre time point (t(19 degrees of freedom)=3.521, p=0.002, d=1.5) and significantly
higher scores at the post time point compared to the pre time point ($t(9.5 \, \text{df})=4.426, \, p=0.001, \, d=2.3$) (Figure 27). There was no significant difference between scores at the interim and post time points ($t(20 \, \text{df})=0.852, \, p=0.404$).

![Figure 27: Mean scores for Comprehensive Primary Health Care Indicator 'Management style' at pre, interim and post time points](image)

Note: ** Significant difference between pre and interim time point scores ($p<0.01$) Independent Samples t test. *** Significant difference between pre and post time point scores ($p<0.001$) Independent Samples t test.

In the post-program interviews, participants reported a positive impact on the management style over the 12-month period. Two key enabling factors were identified: management style consistent with CPHC values and principles; and consistent management style across all levels of the organisation.

*Management style consistent with CPHC values and principles*

Participants emphasised that management needed to practise the values and principles of CPHC with their employees for the reorientation to CPHC service delivery to be successful. It was reported managers needed to lead by example within the organisation to drive the change needed at the community level. Participants identified five specific management styles that supported CPHC reorientation: empowering; inspiring; trusting; flexible; participatory; and supportive:
We know what we should be doing, but if you don’t believe in it and you’re not practicing it in your own conduct with other people then people will see through it. I’ll use our Primary Health Care Manager as an example - compassionate, very driven, willing to explore things with you until there is mutual benefit and patient in terms of doing that and lets you go the way you need to until you understand the bigger picture of health. (ID03)

Our manager is definitely empowering. There are high levels of trust and flexibility. Flexible in terms of giving you freedom and creativity, I suppose, to take your role where you want to in the CPHC model. (ID09)

Management has been positive and open, but now I think they’re inspiring and empowering and I think that’s because of the manager of the Primary Health Care service. I think her personality and outlook is inspiring. I think that’s really starting to come off on everyone else. I think she had a big impact on how everyone’s starting to be inspired about health promotion. I think it comes down to management being more supportive of the staff. They’re very, very supportive and they’re extremely flexible. (ID04)

I thought management style was excellent from the beginning but I suppose now it’s more working alongside staff and sort of encouraging and supporting us and giving us guidance to work with the CPHC model. We do have a lot of autonomy and I suppose I just feel a lot more support now for us to go ahead with CPHC. (ID10)

Consistent management style across all levels of the organisation

Participants highlighted that consistency in management style between middle and senior management was important to feel supported in CPHC delivery. It was identified that inconsistencies in management styles between middle and senior management caused doubt about the authenticity of senior management support for CPHC which negatively impacted trust:

I feel that the style of our line manager is really empowering and participatory and great, but now, being in the organisation for longer, I’m definitely seeing two levels within management. I’m not seeing that same support and participation from above my line manager and trust issues come in. You don’t feel that the whole organisation is on the same wavelength. It’s definitely our team on the wavelength and not necessarily the organisation, which is to the detriment of the team. This is because it’s not just us who are out meeting with people, it’s the whole organisation’s reputation and people associate us as one. When we’ve got two groups of people working very differently, it’s difficult for the people on the ground to split them up. They put us all in the same box. So if they’ve had an experience on the ground that’s different to the experience with me then maybe next time they’ll think of me in the same way and that’s not to my benefit. (ID13)

4.2.1.2.14 Management practices

At the pre time point, the mean response for the indicator ‘Management practices’ was 2.0 (SD=0.6), placing it in the Proactive category. At the interim time point, the mean response was 2.7 (SD=0.5), in the High Performing
category. At the post time point, the mean response was 2.8 (SD=0.4), also in the *High Performing* category.

The difference between the mean scores was 0.7 (95% CI 0.2-1.3) between pre and interim time points; 0.1 (95% CI -0.4-0.5) between the interim and post time points; and 0.8 (95% CI 0.2-1.4) between pre and post time points. Participants reported significantly higher scores at the interim time point compared to the pre time point (*t*(15 degrees of freedom)=2.714, *p*=0.016, *d*=1.3) and significantly higher scores at the post time point compared to the pre time point (*t*(13)=2.822, *p*=0.014, *d*=1.5) (Figure 28). There was no significant difference between scores at the interim and post time points (*t*(18)=0.247, *p*=0.808).

![Figure 28: Mean scores for Comprehensive Primary Health Care Indicator 'Management practices' at pre, interim and post time points](image)

*Note:* * Significant differences between pre and interim time point scores and pre and post time point scores (*p*<0.05) Independent Samples t test.

In the post-program interviews, participants reported a positive impact on management practices over the 12-month period. CPHC philosophy embedded into team function was identified as a key support for CPHC delivery, hence embedding the philosophy into all aspects of the team’s function was identified as an important management practice. Participants reported CPHC philosophy was introduced into: formal and informal team meetings; planning; reporting; and evaluation:
We have different things in place in terms of the Comprehensive Primary Health Care philosophy. We've got different types of meetings and get-togethers with different parts of the team and with management and I feel that is really strong practice. So we're constantly reminded by management about how to practise CPHC through our planning days, reflection meetings and reporting template. It's a constant reinforcement of what it is and how we work within it. I think that's a really great practice that management has introduced. (ID06)

I think management is very much into comprehensive practices. This is evident in the new practices that the team is now doing. It's trickling down to the team in planning and reporting templates and our meetings. Our evaluation processes are based on CPHC philosophy. (ID11)

4.2.1.2.15 Planning processes conducted by managers

At the pre time point, the mean response for the indicator ‘Planning processes conducted by manager’ was 1.7 (SD=0.8), placing it in the Proactive category. At the interim time point, the mean response was 2.7 (SD=0.7), in the High Performing category. At the post time point, the mean response was 2.8 (SD=0.7), also in the High Performing category.

The difference between the mean scores was 1.0 (95% CI 0.2-1.8) between pre and interim time points; 0.1 (95% CI -0.6-0.7) between the interim and post time points; and 1.1 (95% CI 0.3-1.9) between pre and post time points. Participants reported significantly higher scores at the interim time point compared to the pre time point (t(14 degrees of freedom)=2.746, p=0.016, d=1.4) and significantly higher scores at the post time point compared to the pre time point (t(13)=2.896, p=0.013, d=1.5) (Figure 29). There was no significant difference between scores at the interim and post time points (t(17)=0.252, p=0.804).
In the post-program interviews, participants reported a positive impact on the planning processes conducted by managers over the 12-month period. Management including staff in the planning process was identified as positive. Two key challenges that impact on planning processes were also identified: transparency of the planning process; and how program funding is provided by the government.

**Management including staff in planning processes**

Participants identified that management including staff and other services in planning processes was a positive change as it enabled community feedback to be passed onto management:

*Towards the end of the last 12 months I've very much seen managers working a lot more with services and especially working in with the staff at the front of it [service delivery]. So managers are very much getting us involved in planning and evaluation. I think it's really good for them to get that feedback from the people who are working at the pointy end of it. (ID03)*

**Transparent planning processes**

Participants identified the planning processes that management used could be improved if they were made more transparent. It was highlighted participants had little understanding of management planning:
I don’t know how much management plan or what they plan about. I think there’s a lot of planning that goes on with management to pull all this stuff off but it would be good to know more about it and how our plans contribute to theirs. (ID02)

Funding impact on management’s planning processes

The means by which the government provides funding to health services was identified as having a negative impact on management planning processes. Participants highlighted that management cannot carry out true needs-assessments and planning processes reflective of community-identified needs because the government pre-determines the issue(s) to be addressed before funding is released. It was reported this severely limits management’s capacity to use CPHC-focused planning processes:

I just think that a lot of the program priorities are set by the government at a national level ….they say what the issues are and the funding comes out, like maternal and child health stuff at the moment. What our organisation, or other regional organisations, will do is go and get a big bucket of money around that. That determines the priority for the organisation and for the community. I have big problems with the way funding comes out to address health issues and I think we’ve got no say really in how or what because we are all relying on government funding to keep organisations going. (ID01)

4.2.1.2.16 Management understanding of health

At the pre time point, the mean response for the indicator ‘Management understanding of health’ was 2.3 (SD=0.8), placing it in the Proactive category. At the interim time point, the mean response was 3.0 (SD=0.0), in the High Performing category. At the post time point, the mean response was 2.9 (SD=0.3), also in the High Performing category.

The difference between the mean scores was 0.7 (95% CI 0.0-1.4) between pre and interim time points; 0.1 (95% CI -0.4-0.1) between the interim and post time points; and 0.6 (95% CI -0.1-1.3) between pre and post time points. Participants reported significantly higher scores at the interim time point compared to the pre time point (t(6.0 degrees of freedom)=2.500, p=0.047, d=1.9) (Figure 30). There was no significant difference between scores at the interim and post time points (t(8.0 df)=1.000, p=0.347) or scores at the pre and post time points (t(7.8 df)=1.968, p=0.086).
In the post-program interviews, participants reported a positive impact on management’s understanding of health over the 12-month period. Four key enablers were identified: broad view of health determinants; facilitating CPHC-focused professional development; CPHC-focused policies and procedures; and team contribution to CPHC-focused change. Participants also identified a difference between middle and senior management understanding of health.

Broad view of health determinants

Having a broad view of health determinants was identified as important for management’s understanding of health. Participants identified that when managers held a holistic view of health this enabled them to work on more upstream measures supporting long term, sustainable change:

Management’s understanding of health is acknowledged and evidenced through the CPHC projects that we run. We align our projects with the social determinants of health. Management see our role as a service to contribute to addressing issues and creating healthy conditions and communities. (ID07)

Management talk about [CPHC] in everything. Our manager is driving for delivery in that direction rather than just being about clinical secondary and tertiary care. It’s definitely about chronic disease prevention and promoting health. Not just a narrow view of health but health in social, emotional, mental – the whole picture. Then looking at grassroots causes for health, not just going, ‘Oh, they’re not eating
well’. It’s like, ‘Why aren’t they eating well?’. We are encouraged to think about ‘why’ on so many levels. (ID08)

Facilitating CPHC-focused professional development
Participants stated management’s understanding of health was evident though the facilitation of several CPHC and health promotion-focused professional development opportunities:

I thought that how we were doing our work earlier was very reactive and I don’t know that too many people had any idea. The Primary Health Care Manager has done a lot of work around what health promotion really is and has narrowed it down for many and now every worker in our team is familiar with health promotion principles and how these principles are used in our work out there. (ID06)

Management understanding of health is really evident in: a) the training; and b) the up skilling that we get at work. We constantly talk about the midstream, upstream, downstream practice, for example, and we also report against those now. (ID03)

CPHC-focused policies and procedures
Participants stated having CPHC-focused policies and procedures demonstrated management’s broad understanding of health. It was identified that having policies and procedures in place supported the team to action the CPHC philosophy rather than just understand it:

Management’s understanding of health is evident in recruitment choices. They have employed Indigenous people to link in better with community needs. They have health promotion people who know how to do planning and evaluation. They have gone to that more holistic team structure and have reporting and planning processes that are more comprehensive. I suppose CPHC has become more operational – it’s more than a philosophy now. (ID09)

There’s support, there’s time, there’s understanding that it takes time to plan these [health promotion] things. You’re not asked by management ‘What did you do for those two hours?’ It’s understood the planning process takes time. (ID12)

Team contribution to CPHC-focused change
Participants stated management’s understanding of health was evident in how they enabled the team to contribute to and lead the CPHC-focused change:

I think the understanding of health in this organisation is very good. The leaders know how the smaller things on the ground and in our culture are impacting and actually determining health outcomes. Management understands that we
[Indigenous staff] are directly linked to the community and we can lead the change that needs to happen. (ID10)

**Middle and senior management understanding of health**

Disparity in senior and middle management understandings of health was identified. Participants found senior management did not implement the same CPHC-focused changes as middle management over the 12-month period:

*I don’t think the senior managers have implemented [CPHC] into the overall management scheme. The manager of our team has, but not the organisation’s overall management. They don’t really delve into it themselves. If they did there would be more evidence of upstream measures happening and they would incorporate CPHC philosophy into the overall organisation’s strategy and reporting to the board.* (ID05)

*Our manager promotes CPHC and health promotion as important to health in the community. The team understands that and we are all working together. But ideally it would be the whole organisation. We’ve got to feel that senior management and the board has the same thinking, shared knowledge and understanding around the Comprehensive Primary Health Care work. It would be an ideal situation to me if the Board of Directors, the CEO and all of them had shared understandings and knowledge about why and how we’re doing this stuff.* (ID01)

**4.2.1.2.17 Management’s motivation for CPHC work**

At the pre time point, the mean response for the indicator ‘Management’s motivation for CPHC work’ was 1.9 (SD=0.7) placing it in the **Reactive** category.

At the interim time point, the mean response was 3.0 (SD=0.0), in the **High Performing** category. At the post time point, the mean response was 2.8 (SD=0.4), also in the **High Performing** category.

The difference between the mean scores was 1.1 (95% CI 0.5-1.8) between pre and interim time points; 0.2 (95% CI -0.6-0.1) between the interim and post time points; and 0.9 (95% CI 0.3-1.5) between pre and post time points. Participants reported significantly higher scores at the interim time point compared to the pre time point (t(6.0 degrees of freedom)=4.382, p=0.005, $d=3.3$) and significantly higher scores at the post time point compared to the pre time point (t(14 df)=3.254, p=0.006, $d=1.6$) (Figure 31). There was no significant difference between scores at the interim and post time points (t(8.0 df)=1.512, p=0.169).
In the post-program interviews, participants reported a positive impact on management’s motivation for CPHC work over the 12-month period. Three key values that demonstrated management’s motivation were identified: respect for health promotion processes; focus on long term health outcomes rather than short-term monetary gain; and recognition health promotion is everyone’s responsibility.

**Respect for health promotion processes**

Management respect for health promotion processes was identified as a key value that demonstrated management’s motivation for CPHC work:

> To start with we operated with a real clinical focus. But since the Primary Health Care Manager came on it has really improved. Management is on board, the health promotion roles are in place and the way that they work with the whole team is really well understood. (ID02)

> Health promotion is pretty strong in the organisation so I suppose there’s always motivation for the team to work in that Comprehensive Primary Health Care model. (ID04)

> I just think now the main difference is that it’s very, very evident that management see health promotion as a key component of what the division stands for. (ID08)

**Focus on long-term health outcomes rather than short-term monetary gain**
Management focusing on long term health outcomes was identified as a key value demonstrating motivation for CPHC work. Participants highlighted that management’s focus on long term health outcomes rather than short term monetary gain helped them feel supported to invest time in CPHC-focused activities that did not necessarily produce immediate quantitative-based results:

I feel highly supported to do CPHC because I feel that health promotion work is valued. If I have spent three hours on something which is not about statistics I don’t have to justify what I did with that three hours. It’s acknowledged that CPHC outcomes take time and having two meetings with people just to discuss something and to start getting ideas is okay. Rather than, ‘How many people did you see? How much money did you make us?’ I think that that’s good, the values and needs are great. (ID12)

Our manager showed us the difference between selective and comprehensive [Primary Health Care], the pros and cons to each and how selective Primary Health Care is not going to do much for us and that comprehensive is where we need to be at for long term health outcomes. It’s really motivating to know our manager wants us to work within the comprehensive model as opposed to the historical selective model, even though it would probably generate more money and be easier to report on. (ID06)

I think the organisation is visionary, inspiring and committed to the CPHC philosophy and I think CPHC is integrated into core business. I think that because our manager continues to support us after reporting back that we’ve been sitting under a mango tree with a bowl of watermelon chatting to school kids. It is understood that doing that is ‘real’ work and we don’t have to justify why we did that. (ID05)

**Health promotion is everyone’s responsibility**

Management emphasising that health promotion is everyone’s responsibility rather than the sole role of Health Promotion Practitioners was highlighted as a key value that demonstrated management’s motivation for CPHC work:

Health promotion is valued and recognised by management as an important part of all staff roles. That’s through the position descriptions and weekly reports and action plans. Everything we do is really based around health promotion processes and principles. (ID07)

**4.2.1.2.18 Leadership in CPHC**

At the pre time point, the mean response for the indicator ‘Leadership in CPHC’ was 1.8 (SD=0.5), placing it in the *Proactive* category. At the interim time point, the mean response was 2.9 (SD=0.4), in the *High Performing* category. At the post time point, the mean response was 2.7 (SD=0.5), also in the *High Performing* category.
The difference between the mean scores was 1.1 (95% CI 0.7-1.5) between pre and interim time points; 0.2 (95% CI -0.6-0.2) between the interim and post time points; and 0.9 (95% CI 0.4-1.4) between pre and post time points. Participants reported significantly higher scores at the interim time point compared to the pre time point (t(19 degrees of freedom)=5.951, p=0.000, d=2.6) and significantly higher scores at the post time point compared to the pre time point (t(15)=3.905, p=0.001, d=1.9) (Figure 32). There was no significant difference between scores at the interim and post time points (t(20 df)=0.963, p=0.347).

Figure 32: Mean scores for Comprehensive Primary Health Care Indicator 'Leadership in Comprehensive Primary Health Care' at pre, interim and post time points
Note: *** Significant differences between pre and interim time point scores and pre and post time point scores (p<0.001) Independent Samples t test.

In the post-program interviews, participants reported a positive impact on leadership in CPHC over the 12-month period. Three key factors that demonstrated leadership in CPHC were identified: a manager with experience in and commitment to CPHC; support for ongoing quality improvement processes; and sharing CPHC knowledge and resources with partnering organisations.

A manager with experience in and commitment to CPHC
Having a manager with experience in and commitment to CPHC was identified as a key enabler for leadership in CPHC:

Impact evaluation of a CPHC ODS on a health service’s capacity to deliver comprehensive primary health care
Our Primary Health Care Manager is an important role that leads CPHC within the organisation. She has a lot of commitment to CPHC. She has a lot of experience and passion. I can see when we’re all together that just rubs off on everyone and everyone starts to feel what she feels. It is inspiring. (ID04)

Having a Cape York Primary Health Care Manager installed in our program to facilitate changes has really identified what needs to be changed and done. Changes to the reporting as well has shown us a better path to practise in a new approach/model. We have actually had a clear definition of what [CPHC] stands for and how changes in this approach occur. That, through management, has filtered down to us. (ID03)

Support for ongoing quality improvement processes
Support for ongoing quality improvement processes was identified as a key factor that demonstrated leadership in CPHC. Participants highlighted having good team communication systems which allow people to reflect on and acknowledge areas for improvement was an important aspect of leadership in CPHC:

I think our manager is pretty good at acknowledging there's always room to improve, to acknowledge that we may need to change our processes and ways in the community. I feel there are ears there [in the organisation] to hear that. I think because we have good communication processes everyone sees where we can improve and how we might be able to do that. Our team has come together a lot more and I think our leadership has helped us to improve a lot. (ID11)

Sharing CPHC knowledge and resources with partnering organisations
Participants highlighted that having permission to support other health services in CPHC delivery through knowledge and resources demonstrated that the team were leaders in CPHC:

The team is definitely viewed as the leaders in CPHC and people are asking for support in creating their own [health promotion action] plans from the Health Promotion Practitioners. Management has definitely allowed the team to provide that support, even though you could say it’s not our core business to do that. (ID01)

Management is more than happy about us supporting other health services to deliver CPHC across the Cape. The team invests a lot of time in other health service teams which don’t have as many CPHC resources and that’s just really great. The team will go up specifically to travel to areas to provide that support to other teams and our partners; that’s in our interest to achieve long term health outcomes as well. It’s just really good to see that they’ll do that over, perhaps catching up on their own work in the office. They’re putting it [CPHC support] first. (ID03)

4.2.1.2.19 Consultation processes with the community
At the pre time point, the mean response for the indicator ‘Consultation processes with the community’ was 1.3 (SD=0.5), placing it in the Reactive category. At the interim time point, the mean response was 1.9 (SD=0.5), in the Proactive category. At the post time point, the mean response was 2.2 (SD=0.8), also in the Proactive category.

The difference between the mean scores was 0.6 (95% CI 0.1-1.1) between pre and interim time points; 0.3 (95% CI -0.4-1.0) between the interim and post time points; and 0.9 (95% CI 0.2-1.7) between pre and post time points. Participants reported significantly higher scores at the interim time point compared to the pre time point (t(17 degrees of freedom)=2.624, p=0.018, $d=1.3$) and significantly higher scores at the post time point compared to the pre time point (t(14 df)=2.631, p=0.020, $d=1.4$) (Figure 33). There was no significant difference between scores at the interim and post time points (t(12.493)=0.970, p=0.351).

![Figure 33: Mean scores for Comprehensive Primary Health Care Indicator 'Consultation processes with the community' at pre, interim and post time points](image)

Note: * Significant differences between pre and interim time point scores and pre and post time point scores (p<0.05) Independent Samples t test.

In the post-program interviews, participants reported a positive impact on consultation processes with the community over the 12-month period. Four key factors that enabled community consultation processes were identified: understanding the value of community consultation processes; inclusion of a
partnership strategy in discipline-specific health promotion action plans; understanding how the Indigenous Community Development Liaison Officer role supports community consultation processes; and understanding that health promotion strategies facilitate community consultation processes. Participants also highlighted that establishing a whole-of-team formal community consultation process would strengthen its community consultation capacity. Guidelines and deliverables attached to program funding were identified as a key challenge that impact on quality community consultation processes taking place.

Understanding the value of community consultation processes

Understanding the value of community consultation processes was identified as a key enabler. Participants reported they felt the organisation understood the importance of community feedback and its link to continuous quality improvement in the context of achieving sustainable health outcomes:

I think initially maybe we had our blinkers on as an organisation. Now it’s really clear the division is focused on improvement and taking or getting external feedback and actually doing it formally, making the organisation look at QI [quality improvement] in a structured way. (ID02)

Partnership strategy in discipline-specific health promotion action plans

Including specific partnership strategies in health promotion action plans was identified as a key enabler to guide each discipline in carrying out community consultation processes:

We’ve got our partnership strategy built into our [health promotion action] plan which means that we do get everyone on board in the community to tell us what they need and how to use our services. The plans are live documents that can be changed so we can change our services to suit what people want. The partnership strategy in our plans is helpful to make sure the community is telling us what they want and we are not just off doing what we might think is important. (ID05)

At the actual planning phase I would normally have something down that I had an idea on how I thought we could roll out say a food security program for example. But now, through the partnership strategy, I go to community and say, ‘What are your ideas?’ I get different ideas on how we can do things. This has allowed me to find out what activities [the community] really want. (ID08)

Understanding how the Indigenous Community Development Liaison Officers role supports community consultation processes
Better understanding of how the Indigenous Community Development Liaison Officer role supported community consultation processes was identified as a key enabler to carry out quality consultation processes. The Indigenous Community Development Liaison Officers highlighted positive changes in consultation processes when the non-Indigenous staff had a better understanding of their links to community and how this could be maximised to develop a clear understanding of community wants and needs:

A lot of the contact on the ground or at the community level didn’t come through, didn’t feed through to the organisation in the beginning stages. And it’s slowly started. I suppose there wasn’t a lot of understanding about my role [Indigenous Community Development Liaison Officer] and how the team could work with it. We had to work out exactly what it was and I think working that out has increased quite a lot working in between the community and the team. So I think that slow progression of understanding what my role is and going through all of the different stages of understanding that and the team understanding, and me showing the community, or listening to the community, in that way has changed. Just the establishment of my role probably helped and just the understanding of it probably helped with community feedback. I think you do get quite a lot of community feedback through [Indigenous Community Development Liaison Officer roles]. Community is probably a lot more open too, I suppose giving us information about their needs to take to the organisations). (ID10)

Understanding that health promotion strategies facilitate community consultation processes

Understanding that health promotion strategies facilitate community consultation processes was identified as a key contributor to community consultation processes:

Now that we have begun focusing on specific health promotion strategies and activities more whole-of-community community consultation is taking place. But unless you’re doing health promotion activities out there, you’ll always just be getting individual’s feedback rather than whole-of-community. (ID11)

Establish whole-of-team formal community consultation processes

Participants identified the need for the organisation to formalise a whole-of-team community consultation process. The need for clear processes and guidelines about how community consultation takes place and informs programs was recommended. It was considered inappropriate for the Indigenous staff to carry the full responsibility of the organisation’s consultation processes and could be, at times, culturally unsafe due to community dynamics:
I think a lot of the community feedback we’ve been given, now is not from the community, it’s more through our Indigenous workers. I’m not 100 per cent sure whether all our Indigenous workers live in a community and whether the input we get back from those guys is 100 per cent reflective of all community needs. I have always found that we’ve been lacking direct community input. Communities don’t really get a chance to get their input into what services do and where programs are. (ID13)

There’s still no way that we get any real formal feedback. The staff come back with good comments, people come up to me and say about the work that we do and that comes from individuals. Whereas wouldn’t it be nice one day to get a letter from the council or somebody that compliments the organisation and the work that it does? Or even just a letter to say, ‘We’re doing this, can you do it this way?’ There’s not too much formal community input in the stuff that we do. It’s still mostly informal. (ID01)

We are always trying to have more community input. We’re always trying to get information and work with people rather than working for them. So from that point of view we are definitely supporting community input and we’re canvassing for it. We’re trying to build it and get more and more community input so that the community is building what they want. So that’s really great, but we aren’t getting as much as we’d like. I think we need to learn as an organisation how we can do it better. (ID05)

I think we’re always trying to do community consultation. I think there’s still quite a lot to learn to make sure we don’t skip very vital parts of engagement. I think we still have to do a lot of listening and a lot of watching and there’s still a lot of trust that communities need towards any services, especially the communities where they’ve got so many [services] where those engagement processes aren’t there. (ID10)

Guidelines and deliverables attached to program funding

Guidelines and deliverables attached to program funding were identified as challenging factors that can restrict health services from conducting proper community consultation. Participants identified that when a health services relies on external funding they need to follow pre-determined guidelines and deliverables that do not necessarily take community feedback into account and therefore don’t value the need for quality community consultation to take place:

- We all want community feedback and community involvement but in practice it’s a tough thing to do and we do have funding bodies and we do have to get our plans in so unfortunately we have to rush things and it means that we do sometimes miss that part. (ID08)

- I think that unfortunately we are kind of influenced by time-frames from funding bodies and we just can’t take the time we need to do proper community consultation processes. (ID07)

- Instead of setting priorities at that senior government level, somewhere we’ve got to make the connection with the local people about what they see as their health issues, not what we or other outsiders see as their health issues. I think we can work better with communities if we do it that way. (ID01)
4.2.1.2.20 Consultation processes with key stakeholders

At the pre time point, the mean response for the indicator ‘Consultation processes with key stakeholders’ was 1.4 (SD=0.5), placing it in the Reactive category. At the interim time point, the mean response was 2.0 (SD=0.4), in the Proactive category. At the post time point, the mean response was 2.2 (SD=0.7), also in the Proactive category.

The difference between the mean scores was 0.6 (95% CI 0.5-1.1) between pre and interim time points; 0.2 (95% CI -0.3-0.7) between the interim and post time points; and 0.8 (95% CI 0.1-1.5) between pre and post time points. Participants reported significantly higher scores at the interim time point compared to the pre time point (t(10.5 degrees of freedom)=2.415, p=0.035, d=1.2) and significantly higher scores at the post time point compared to the pre time point (t(14 df)=2.567, p=0.022, d=1.3) (Figure 34). There was no significant difference between scores at the interim and post time points (t(19 df)=0.932, p=0.363).

Figure 34: Mean scores for Comprehensive Primary Health Care Indicator ‘Consultation processes with key stakeholders’ at pre, interim and post time points

Note: * Significant differences between pre and interim time point scores and pre and post time point scores (p<0.05) Independent Samples t test.

In the post-program interviews, participants reported a positive impact on consultation processes with the community over the 12-month period. Two key
enabling factors were identified: partnerships across all levels of the organisation; and inclusion of a partnership strategy in health promotion action plans. Challenges that impact on consultation processes with key stakeholders were also identified: processes for stakeholder consultation; the competitive nature of funding; and formal partnerships with key stakeholders.

**Partnerships across all levels of the organisation**
Developing partnerships across all levels of the organisation was identified as a key factor that contributed positively to consultation processes with key stakeholders:

*I think we are definitely consulting with key stakeholders on the ground, chatting with them about what they think of our service and what they think of our program. We always feed that back to management.* (ID09)

*We are sourcing evaluation from partners and I guess that happens on a few different levels. Not only with specific programs that are run, but then also around staff themselves from formal management meetings.* (ID07)

**Partnership strategy in discipline-specific health promotion action plans**
Including specific partnership strategies in health promotion action plans was identified as a key enabler for each discipline carrying out consultation processes with key stakeholders:

*With all our [health promotion action] plans and the evaluation processes to get community input and other stakeholders’ input we have started to develop consultation processes. They are written into our plans, now we just have to follow it up, which has been happening.* (ID06)

*We’ve got our partnership strategy built into our [health promotion action] plan which means that we do get everyone on board in the community to tell us what they need and how to use our services.* (ID12)

**Processes for stakeholder consultation**
Participants found consulting with key stakeholders may be confusing without an understanding of how the political environment(s) might impact the process. Participants reported it was important for management to have a clear sense of stakeholder direction and share any political agendas that may impact on participants carrying out consultation processes:

*I think we do our best as an organisation. The company is Primary Health Care and if you’re looking at that, and the current climate that we’re in, there’s not a lot*
of people that work along that way. So we’re sort of right out there on our own. (ID09)

I think we’re still coming to terms with how to operate and work with the other organisations and stakeholders. Because of what’s happening politically, I think organisations have got different principles that they’re working by. And I think at the moment, we’re still trying to find our feet with CPHC and stick to our guns. Because I do see the other organisations that we work with, some of them are up in the air about their operation. I do see there is very unclear ground to walk on at the moment. It’s like we’re sort of missing a piece on how to work with the other organisations. (ID13)

**Competitive nature of funding**

The competitive nature of how program funding is released was identified as a key factor that impacts negatively on consultation processes between key stakeholders. Participants highlighted that as long as health services are competing with each other for program funding, the potential for genuine consultation processes will be limited:

*We work in partnerships and we’re trying to work as one and it isn’t always happening. That seems to be because partners want recognition for what they do maybe, rather than just achievement of a common goal. (ID12)*

*It’s a competitive environment up here for funding so when most organisations get funding for stuff they think about their stuff first and then bring in the other people. There is a bit of an inward focus in terms of how resources are firstly gained and then used. Perhaps another funding approach would benefit services to work more collaboratively. It would be better if it was set up in a way that before getting the funding, health services have to look at what’s out there and see what sort of partnerships and collaborations they can use to leverage resources. (ID02)*

**Formal partnerships with key stakeholders**

Participants identified the need for the organisation to formalise partnerships with key stakeholders. It was highlighted that formal relationships would ensure consultation was not reliant on the goodwill of staff members:

*We don’t have any formal kind of relationships with them [key stakeholders], networking things with the Indigenous councils, community councils, or health action teams. Some team members do it but it is not a standard process. I think we’ve got a long way to go as an organisation in working in formal partnership work with other organisations. There’s a lot of scope for improvement there. (ID01)*

*A shared vision on how we do consultation is important. We haven’t done that properly and that’s what I think would help the organisation a lot. (ID11)*

4.2.1.2.21 Summary of results for research sub-question two
Research sub-question two asked: What is the impact of a CPHC ODS on FNQRDGP’s organisational processes? From the pre to post time points, 17 of the 20 twenty indicators of organisational processes had statistically significant increases with medium to very large effect sizes, indicating movement in a positive direction towards increasing FNQRDGP’s capacity to deliver CPHC (Table 17). Seven of the indicators shifted from Reactive to High Performing, eight shifted from Proactive to High Performing, and two shifted from Reactive to Proactive.

Of the eight indicators within the Organisational systems sub-component, six had significant increases, with three shifting from Reactive to High Performing and three from Proactive to High Performing. All four indicators within the Organisational structures sub-component had significant increases, with two shifting from Reactive to High Performing and two from Proactive to High Performing. Within the Organisational leadership sub-component, all six indicators had significant increases, with three shifting from Reactive to High Performing and three from Proactive to High Performing. Within the External environment sub-component, both indicators increased significantly from Reactive to Proactive.

Key enablers identified as being necessary to increase FNQRDGP’s capacity to deliver CPHC were: 1) leadership with experience in and commitment to CPHC practice; 2) CPHC values and principles embedded in all aspects of the organisation’s functions; 3) health promotion embedded within all areas and levels of the organisation; 4) dedicated time to reflect and evaluate organisation’s actions across CPHC continuum; 5) value and support to conduct community engagement processes; 6) team structure reflects horizontal network compared to a hierarchical structure; 7) CPHC information sharing systems; and 8) consistent communication direction and style between all levels of the organisation.

Key barriers identified as limiting FNQRDGP’s capacity to deliver CPHC were: 1) guidelines and deliverables attached to program funding; 2) the competitive
nature of funding between health services; and 3) partnerships with key stakeholders.
### Table 17: Research sub-question two quantitative results summary

<table>
<thead>
<tr>
<th>CPHC ODS Component</th>
<th>CPHC ODS sub component</th>
<th>Indicators</th>
<th>t</th>
<th>p</th>
<th>d*</th>
<th>Categorical change**</th>
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<tr>
<td>Organisational Processes</td>
<td>Organisational systems</td>
<td>6. Communication direction</td>
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<td>7. Reference to CPHC in policies</td>
<td>3.902</td>
<td>0.002</td>
<td>2.0 (VL)</td>
<td>R-HP</td>
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<td>8. Support for health promotion program planning</td>
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<td></td>
<td>9. Whole-of-team meetings inclusion of CPHC and health promotion</td>
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<td>2.2 (VL)</td>
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<td></td>
<td>10. Type of quality improvement within programs</td>
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<td>R-HP</td>
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<td>11. Reflection on program goal and objectives aligned with CPHC principles</td>
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<td>12. Process for determining program priorities</td>
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<td>13. Reward systems for achievements in CPHC work</td>
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<td>1.3 (L)</td>
<td>R-P</td>
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</table>

* M=medium, L=large, VL=very large
** R-P = mean score for indicator changed from Reactive category to Proactive category, P-HP = Proactive to High Performing, R-HP = Reactive to High Performing

#### 4.2.1.3 Research sub-question three results

Research sub-question three asked: What is the impact of a CPHC ODS on FNQRDGP’s organisational culture? Impact on organisation culture was assessed against 12 CPHC indicators (Refer to Appendix 10). Results for each indicator are described below.

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Impact evaluation of a CPHC ODS on a health service’s capacity to deliver comprehensive primary health care
4.2.1.3.1 Mission and strategy
At the pre time point, the mean response for the indicator ‘Mission and strategy’ was 1.9 (SD=0.4), placing it in the Proactive category. At the interim time point, the mean response was 2.6 (SD=0.5), in the High Performing category. At the post time point, the mean response was 2.8 (SD=0.7), also in the High Performing category.

The difference between the mean scores was 0.7 (95% CI 0.3-1.2) between pre and interim time points; 0.2 (95% CI -0.4-0.7) between the interim and post time points; and 0.9 (95% CI 0.2-1.5) between pre and post time points. Participants reported significantly higher scores at the interim time point compared to the pre time point (t(16 degrees of freedom)=3.522, p=0.003, d=1.6) and significantly higher scores at the post time point compared to the pre time point (t(13 df)=2.980, p=0.011, d=1.8) (Figure 35). There was no significant difference between scores at the interim and post time points (t(16 df)=0.612, p=0.548).

In the post-program interviews, participants reported a positive impact on mission and strategy over the 12-month period. Two key enabling factors were identified: structural change to support the mission and strategy; and time with...
management to discuss the mission and strategy. Participants differentiated between the mission and strategy at the team and organisational level and highlighted differences between the two.

**Structural change to support mission and strategy**

Changing the organisation’s structure to incorporate a Primary Health Care Manager was identified as a key factor with a positive impact on the organisation’s mission and strategy:

> The improvement in our strategy is a result of the structural change in regards to the Primary Health Care Manager position. This has enabled us to talk with management about health promotion and our ability to reach and engage with the community. (ID03)

**Time with management to discuss mission and strategy**

Having time with management to discuss the mission and strategy was identified as another key factor with a positive impact on the organisation’s mission and strategy:

> I got to sit down with the Primary Health Care Manager and actually talk about what the mission and values and objectives are of the organisation. I felt that it was looking outward and it was comprehensive. (ID09)

**Differences between mission and strategy at the team and organisational level**

Participants highlighted that the organisation had not changed its mission and strategy to reflect CPHC principles and values. It was suggested that the organisation needed to update its formal mission and strategy to better align with CPHC:

> As an organisation we haven’t changed the mission and strategy but we certainly have changed in the team - definitely. We’re more health promotion and CPHC-focused. (ID07)

> The organisation’s mission and strategy has a bit of a preventative and clinical care service focus. It’s more based on the GP (General Practice) side of things, though. It needs to be updated, I think, to include the Primary Health Care movements. (ID06)
4.2.1.3.2 Strategic direction

At the pre time point, the mean response for the indicator ‘Strategic direction’ was 1.7 (SD=0.5), placing it in the Proactive category. At the interim time point, the mean response was 2.9 (SD=0.3), in the High Performing category. At the post time point, the mean response was 2.9 (SD=0.3), also in the High Performing category.

The difference between the mean scores was 1.2 (95% CI 0.7-1.8) between pre and interim time points; 0.3 (95% CI 0.4-0.3) between the interim and post time points; and 1.2 (95% CI 0.7-1.7) between pre and post time points. Participants reported significantly higher scores at the interim time point compared to the pre time point (t(7 degrees of freedom)=5.412, p=0.001, d=3.0) and significantly higher scores at the post time point compared to the pre time point (t(12 df)=5.216, p=0.000, d=2.9) (Figure 36). There was no significant difference between scores at the interim and post time points (t(17 df)=0.226, p=0.824).

![Figure 36: Mean scores for Comprehensive Primary Health Care Indicator 'Strategic direction' at pre, interim and post time points](image)

Note: *** Significant differences between pre and interim time point scores and pre and post time point scores (p<0.001) Independent Samples t test.

In the post-program interviews, participants reported a positive impact on strategic direction over the 12-month period. Three key enabling factors were identified: dedicated management position for Primary Health Care; clear definition of team roles; and CPHC processes embedded in team functions.
Impact evaluation of a CPHC ODS on a health service’s capacity to deliver comprehensive primary health care

Dedicated management position for Primary Health Care

Having a dedicated management position for Primary Health Care was identified as a key factor that strengthened the strategic direction in CPHC. Participants identified that having a role devoted to Primary Health Care created a clear CPHC-focused strategic direction:

Since the new position for managing Primary Health Care was developed we have had clear direction on the CPHC approach. I think everyone in the whole organisation has embraced the principles of Primary Health Care, as a way of improving the outcomes for communities. We may have a way to go before full implementation, but at least we are embracing the principles. (ID03)

Having a position devoted to managing Primary Health Care has really moved us, it has created that different vibe that we’re very much into the comprehensive model now. The Primary Health Care Manager has created a culture. She’s always influencing us in that direction with plenty of reminders via her email or in how she approaches solving problems or looking at issues. She’s always coming from that perspective. I guess that has a flow-on effect. (ID06)

Clear definition of team roles

Defining team roles and how each team member contributes to achieving CPHC was identified as a key factor in establishing a CPHC-focused strategic direction. Participants highlighted that understanding how they directly contribute to achieving CPHC increased clarity around the CPHC-focused strategic direction:

We understand how our specific discipline needs to achieve CPHC and how health promotion helps us do that through Ottawa Charter action areas. (ID06)

Job descriptions have been changed to reflect how each discipline can achieve CPHC. CPHC duties and accountabilities are now part of everyone’s overall direction. (ID09)

CPHC processes embedded in team function

Embedding CPHC processes in team functions was identified as a key factor that enabled a CPHC-focused strategic direction. Participants highlighted that the introduction of CPHC-focused meetings, planning, reporting and reflection sessions contributed to a clear strategic direction:

Now our direction is to have more of a planned response to what we know the health issues are. Initially someone might work in more of an ad hoc manner, whereas now the division has been working with people to document what the major health issues and determinants are and then getting solid plans in place so
that we work in a more structured way to address health needs in the long term not just short term projects. (ID05)

4.2.1.3.3 Level of care
At the pre time point, the mean response for the indicator ‘Level of care’ was 2.0 (SD=0.0), placing it in the Proactive category. At the interim time point, the mean response was 2.9 (SD=0.3), in the High Performing category. At the post time point, the mean response was 2.9 (SD=0.3), also in the High Performing category.

The difference between the mean scores was 0.9 (95% CI 0.7-1.2) between pre and interim time points; 0.03 (95% CI -0.3-0.3) between the interim and post time points; and 0.9 (95% CI 0.6-1.2) between pre and post time points.

Participants reported significantly higher scores at the interim time point compared to the pre time point (t(17 degrees of freedom)=8.300, p=0.000, d=6.3) and significantly higher scores at the post time point compared to the pre time point (t(14 df)=7.000, p=0.000, d=5.3) (Figure 37). There was no significant difference between scores at the interim and post time points (t(19 df)=2.04, p=0.840).

Figure 37: Mean scores for Comprehensive Primary Health Care Indicator ‘Level of care’ at pre, interim and post time points
Note:** Significant differences between pre and interim time point scores and pre and post time point scores (p<0.001) Independent Samples t test.
In the post-program interviews, participants reported a positive impact on level of care over the 12-month period. Three key enabling factors were identified: levels of CPHC knowledge; understanding how to apply CPHC theory into practice; and whole-of-team CPHC reflective opportunities.

**Levels of CPHC knowledge**

Increasing levels of knowledge about CPHC philosophy and theory was identified as a critical enabler to provide a level of care reflective of CPHC. Participants highlighted the value of having regular CPHC training and planning days, information sessions, CPHC-focused meetings and informative emails:

*We have started looking at CPHC and learning how to provide a level of care reflective of this through information sessions and workshops and realising that the team direction is working towards this model. (ID11)*

*We’re looking at the bigger picture as opposed to just looking after a specific problem. Someone might just have a foot problem, we treat them and it ends there, as opposed to now, we’re looking at more, the whole scheme of [CPHC], and looking at the protocols and demand that are more community oriented as opposed to individual care. This level of care has been built into our job descriptions and we know about it - we’re not just looking at feet, we’re talking about quality of lives. (ID06)*

*It has been very clinically based the way we’ve done things, very limited home visits and all these sorts of things and that’s for all sorts of reasons [including] allied health professionals not understanding too much about community. Now we do go quite a lot of home visits and work outside of the clinic. This is because we’ve got a lot more information on the principles of CPHC and not only information, but processes, to go through. I think that has changed our level of care quite a lot. (ID10)*

**Understanding how to apply CPHC theory into practice**

Using a visual model that depicts the full continuum of CPHC in key planning and reporting templates was identified as a key enabler to understanding how to provide a level of care reflective of CPHC. Participants identified that being able to visualise where their daily practice fitted along the CPHC continuum was helpful because it enabled them to ‘see’ and assess their overall level of care. Across the CPHC continuum participants were able to identify: areas of current care provided; gaps in care provided; and opportunities to improve the level of care:

*Having the visual was a great prompt and reminder about how we can achieve CPHC in our daily practice. (ID10)*
Whole-of-team CPHC reflective opportunities

Having whole-of-team CPHC reflective opportunities was identified as an important enabler to improve the level of care reflective of CPHC. Participants highlighted that using a reflective framework to guide team discussions, based on questions about what was working well and what could be improved, strengthened the team’s level of care. Participants also highlighted that through this reflection process individual team members developed a better understanding of how the team functioned as a whole to deliver more coordinated patient-centered care:

*I feel my level of care is more comprehensive now. That’s probably through having more reflection about what’s happening on the ground across the scope [of CPHC] and reporting more across the scope. After speaking more as a whole team, I understand better now how I fit with providing holistic care.* (ID12)

*Throughout the 12 months of the reorientation, I can see how powerful and strong the team is on the ground now that we’re working in a Comprehensive Primary Health Care way. The team has actually changed over the 12 months. People are thinking about what’s happening on the ground – ‘Why am I doing what I’m doing?’ Rather than, ‘I’m doing this because it seems right’, I’m actually doing this because it’s based on these theories and it’s in a plan and heaps more structured and that’s actually working really well on the ground as well.* (ID01)

4.2.1.3.4 Focus of activity

At the pre time point, the mean response for the indicator ‘Focus of activity’ was 2.0 (SD=0.6), placing it in the Proactive category. At the interim time point, the mean response was 2.8 (SD=0.5), in the High Performing category. At the post time point, the mean response was 2.9 (SD=0.3), also in the High Performing category.

The difference between the mean scores was 0.8 (95% CI 0.2-1.3) between pre and interim time points; 0.1 (95% CI -0.2-0.5) between the interim and post time points; and 0.9 (95% CI 0.4-1.4) between pre and post time points. Participants reported significantly higher scores at the interim time point compared to the pre time point (t(16 degrees of freedom)=2.910, p=0.010, d=1.4) and significantly higher scores at the post time point compared to the pre time point (t(13 df)=3.578, p=0.003, d=1.8) (Figure 38). There was no significant difference between scores at the interim and post time points (t(19 df)=0.775, p=0.448).
Figure 38: Mean scores for Comprehensive Primary Health Care Indicator ‘Focus of activity’ at pre, interim and post time points

Note: ** Significant differences between pre and interim time point scores and pre and post time point scores (p<0.01) Independent Samples t test.

In the post-program interviews, participants reported a positive impact on focus of activity over the 12-month period. Three key enabling factors were identified: management understanding of the need for long-term goals; discipline-specific health promotion action plans; and people with in-depth health promotion knowledge and skills.

**Management understanding of the need for long-term goals**

Having management understand the need for long-term goals was identified as a critical enabler to support participants’ focus of activity:

> I feel the organisation actually supports longer term goals. My goal is looking at developing infrastructure and support for people doing physical activity. Management know it’s not a matter of ‘doing’ something. It’s a matter of consulting the community and finding out what they want. Can that be done? How can we do it? Who can we involve? Management get that we need to focus on long term goals and activities if we are going to contribute to sustainable change. (ID09)

**Discipline-specific health promotion action plans**

Developing discipline-specific health promotion action plans was identified as a key enabler that shifted the team’s focus from reactive and short-term tasks to more long-term and sustainable goals:
Through our [health promotion action] plans we are developing strategies that work towards an ultimate goal which is going to take more than a 12-month period. But then, we have been shown how we can break it down to short and medium term objectives. (ID06)

Everyone who participated in our health promotion planning day was thinking, ‘How can we change things long term?’ We have developed goals in our [health promotion] action plans which are definitely long term. (ID08)

**People with in-depth health promotion knowledge and skills**

Having people employed in the organisation with in-depth health promotion knowledge and skills was identified as a key enabler to shift the team focus from reactive to more long term health outcomes:

> I guess with the Primary Health Care Manager and the HPO [Health Promotion Officer] role as well now, we’ve got people with health promotion skills really influencing everybody. With building our plans that we’re all working on, I think that’s an organisational level really creating that focus on sustainable health outcomes. (ID10)

**4.2.1.3.5 Accountability**

At the pre time point, the mean response for the indicator ‘Accountability’ was 2.0 (SD=0.9), placing it in the Proactive category. At the interim time point, the mean response was 2.6 (SD=0.7), in the High Performing category. At the post time point, the mean response was 2.8 (SD=0.7), also in the High Performing category.

The difference between the mean scores was 0.6 (95% CI -0.3-1.5) between pre and interim time points; 0.2 (95% CI -0.5-0.8) between the interim and post time points; and 0.8 (95% CI -0.1-1.6) between pre and post time points. There were no significant differences between scores participants reported at the interim time point compared to the pre time point (t(14 degrees of freedom)=1.500, p=0.156), the interim time point compared to the post time point (t(17 df)=0.556, p=0.579), or the scores at the pre and post time points (t(13 df)=1.936, p=0.075).

In the post-program interviews, participants reported no impact on accountability over the 12-month period. The organisation’s need for formal reporting and community feedback processes was identified as the key reason
for no change. Participants highlighted that the organisation needed to be accountable to the community in order to improve its CPHC approach:

*We haven’t really touched on getting feedback from communities. We get informal feedback but that’s about it. As an organisation we don’t have a process for formal feedback – we need to develop that.* (ID01)

*The organisation’s accountability would improve if we reported to the community what is going on and that may happen at a practitioner level, but it doesn’t at an organisational level.* (ID05)

4.2.1.3.6 Morale

At the pre time point, the mean response for the indicator ‘Morale’ was 1.9 (SD=0.4), placing it in the *Proactive* category. At the interim time point, the mean response was 2.7 (SD=0.5), in the *High Performing* category. At the post time point, the mean response was 2.1 (SD=0.6), in the *Proactive* category.

The difference between the sample mean scores was 0.8 (95% CI 0.4-1.3) between pre and interim time points; 0.6 (95% CI -1.1 0.06) between the interim and post time points; and 0.3 (95% CI -0.3-0.8) between pre and post time points. Participants reported significantly higher scores at the interim time point compared to the pre time point (*t*(17 degrees of freedom)=3.739, *p*=0.002, *d*=1.9) and significantly lower scores at the post time point compared to the interim time point (*t*(19 df)=2.330, *p*=0.031, *d*=1.0) (Figure 39). There was no significant difference between scores at the pre and post time points (*t* (14 df)=0.974, *p*=0.346).
Figure 39: Mean scores for Comprehensive Primary Health Care Indicator ‘Morale’ at pre, interim and post time points
Note: ** Significant difference between pre and interim time point scores (p<0.01) Independent Samples t test. * Significant difference between pre and post time point scores (p<0.05) Independent Samples t test.

In the post-program interviews, participants reported a positive impact on morale over the 12-month period. Four key enabling factors were identified: being listened to and valued by management; being trusted to use initiative; being respected as professionals; and feeling able make a difference. Participants also identified that changes in the external environment can impact negatively on morale.

**Being listened to and valued by management**

Being listened to and valued by management was identified as a key factor facilitating an increase in moral. Participants highlighted that there was a difference between complacent listening and actually being listened to and valued:

*I think individuals have, at the moment, fairly high morale because they’re being listened to and they feel like they’ve been listened to. It wasn’t ever discouraged, I don’t think, but there was complacency around valuing individuals input and work.*

(ID07)

**Being trusted to use initiative**

Being trusted to use personal initiative was identified as a key factor that lead to
an increase in morale. Participants highlighted that being trusted to work in a way they felt was appropriate rather than being told what to do had a positive impact on morale:

*Our manager is supportive and encouraging. We have flexibility and trust to be creative, which is much more morale-lifting than being told what to do or not being able to do your work in the way that you want to.* (ID12)

*Everyone in the team is really motivated because they feel really supported and people have the ability to use their initiative and run with things that are focused on CPHC.* (ID08)

**Being respected as a professional and feeling like you can make a difference**

Participants highlighted that being respected for their professional contribution to the team lead to them feeling they could make a difference which had a positive impact on morale:

*We are respected for our ideas and respected as experts in our field. It might be the podiatrist, for example, and you know the division will really encourage and support whatever initiatives he thinks are needed because he’s on the ground and obviously trained in that field. Everyone just feels like they can make a difference.* (ID13)

**Changes in the external environment**

Changes in the external environment that lead to uncertainty were identified as having a negative impact on morale. Participants found having no control over external changes which directly affect the team had a significant impact on morale:

*Uncertainty has been a key trigger for changes in morale. We are all reacting around the change and our senior managers are as well. I think it falls down to the grassroots level to the practitioners on the ground where you feel the morale is. It’s reduced a little bit, not as high as it has been.* (ID13)

*Morale has recently changed quite a lot, due to the transition going on. The team feels, sort of, ripped off. Just because we don’t know what is going on and so people are feeling like they don’t really know where they’re heading, when they’re going, wherever they’re going. They don’t have the same drive and motivation that they previously had. The team itself is very tight-knit and we’re talking about how we feel amongst ourselves and supporting each other quite well and that’s why I feel as a team, we do have a high morale, but as an organisation it’s definitely dropped quite significantly.* (ID06)

**4.2.1.3.7 Organisational values**
At the pre time point, the mean response for the indicator ‘Organisational values’ was 1.5 (SD=0.5), placing it in the Reactive category. At the interim time point, the mean response was 2.8 (SD=0.4), in the High Performing category. At the post time point, the mean response was 2.6 (SD=0.5), also in the High Performing category.

The difference between the mean scores was 1.3 (95% CI 0.8-1.7) between pre and interim time points; 0.2 (95% CI -0.6-0.2) between the interim and post time points; and 1.1 (95% CI 0.5-1.6) between pre and post time points. Participants reported significantly higher scores at the interim time point compared to the pre time point (t(19 degrees of freedom)=5.932, p=0.000, d=2.6) and significantly higher scores at the post time point compared to the pre time point (t(15 df)=4.094, p=0.001, d=2.0) (Figure 40). There was no significant difference between scores at the interim and post time points (t( 20 df)=1.035, p=0.313).

Figure 40: Mean scores for Comprehensive Primary Health Care Indicator ‘Organisational values’ at pre, interim and post time points
Note: *** Significant differences between pre and interim time point scores and pre and post time point scores (p<0.001) Independent Samples t test.

In the post-program interviews, participants reported a positive impact on organisational values over the 12-month period. Management open to change by working differently was identified as a key enabler. Participants differentiated
between the organisational values at the team and organisational level and highlighted disparity between the two.

Management being open to change by working differently
Management being open to change by working differently was identified as a key factor that enabled a positive change in organisational values. Participants highlighted that management was open to working differently and embraced CPHC values and principles:

Overall, since I’ve been here, the organisation is open to working differently. I think that they embrace CPHC values and principles. Before, there wasn’t too much discussion about it all but over the last few years you’ve seen they are fairly open about it all. When you do talk to higher level management they understand and they’re quite supportive of the whole thing. (ID01)

I see that the organisation values the need to address what others might think of as small issues. Like me being able to pick somebody up - the whole of the community recognises transport as an issue for people to access health services. Because our organisation understands the importance of access in CPHC values and principles our management sees it as, ‘Well, we can help with that at the moment, we can do a bit to help there’. I think that’s good, they don’t block it off and become all bureaucratic with their values. It’s really good. (ID10)

Differences between values at the team and organisational level
Differences between values for the actual team and the whole organisation were identified. Participants highlighted that the organisation had not changed its official value statement to reflect CPHC principles and values. It was suggested that the organisation needed to update its values to better align with CPHC:

The team is supportive of CPHC values but I still think there’s a way to go yet with management coming on board. Again, it’s some management but not all. (ID01)

I know that the values of the team align with CPHC principles but the organisation has not made changes to its official values. (ID07)

This team is very knowledgeable and has a very in-depth understanding of CPHC values and principles. The team has shown how it can be practised and are practising it. I would say, at this stage, because the CPHC values are still new to our overall organisation – changes to the overall values have not yet been made. (ID11)

4.2.1.3.8 Organisation’s response to change
At the pre time point, the mean response for the indicator ‘Organisation’s response to change’ was 2.1 (SD=0.6), placing it in the Proactive category. At the interim time point, the mean response was 2.8 (SD=0.4), in the High Performing category. At the post time point, the mean response was 2.3 (SD=0.7), in the Proactive category.

The difference between the mean scores was 0.6 (95% CI 0.2-1.1) between pre and interim time points; 0.4 (95% CI -0.9-0.1) between the interim and post time points; and 0.2 (95% CI -0.5-0.9) between pre and post time points. Participants reported significantly higher scores at the interim time point compared to the pre time point (t(19 degrees of freedom)=2.745, p=0.013, d=1.2) (Figure 41). There was no significant difference between scores at the interim and post time points (t(20 df)=1.790, p=0.089) or the pre and post time points (t(15 df)=0.633, p=0.536).

![Figure 41: Mean scores for Comprehensive Primary Health Care Indicator 'Organisation's response to change' at pre, interim and post time points](image)

Note: * Significant difference between pre and interim time point scores (p<0.05) Independent Samples t test.

In the post-program interviews, participants reported a positive impact on the organisation’s response to change over the 12-month period. Whole-of-team CPHC reflective opportunities was identified as a key factor which enabled a positive response to change. Participants differentiated between the response...
to change at the team and organisational level and highlighted differences between the two.

**Whole-of-team CPHC reflective opportunities**

Having whole-of-team CPHC reflective opportunities was identified as a key factor that enabled a positive and supportive response to change. Participants highlighted that using a reflective framework to guide team discussions, based on questions about the context of events, strengthened the team’s capacity to explore and understand change and develop a consistent whole-of-team response. It was also identified that developing a team response strengthened its ability to advocate for and influence change with senior management as opposed to acting as individuals with different messages:

> The way the team has responded to change happening and things identified within the community is functional, we’re able to respond as a team to things. It’s really great, it shows that our response is well thought-out during the times we meet and use our reflection templates. So, if we do respond to change and feedback, we use a team process to do it. (ID13)

> I’d say [the organisation] probably takes on a lot more what we say because we are a group, rather than individuals working separately. (ID12)

> We are working more as a team now because I think because we understand each other's roles now and we have a bit more direction on what we’re here for and our approach. I think we’ve sort of come to agreement in some ways on understanding that the CPHC principles are the way to go because we’ve seen how the community responds well to it. (ID10)

**Differences between response to change at the team and organisational level**

Differences between the response to change for the actual team and the whole organisation were identified. Participants highlighted that the organisation’s response to change was not aligned with the CPHC approach:

> The organisation above our team seems to be resisting change and procrastinating to do with the transition. It’s happening no matter how we want to think about it, but it seems like rather than looking at what’s best for the function of the team and for us continuing, it’s what’s best for the organisation. Rather than looking at it being done really well and transparently, it’s just being, ‘How long can we put this off for?’ That’s more, in my view, about business rather than about what’s happening on the ground. (ID09)

> We’ve been supported by senior management to talk about change, but I feel like us voicing our ideas and feeling around change have been completely squashed by having someone external come in and talk about how change is imminent and it’s going to happen, so suck it up and get on with it, rather than talking about how
we felt about change on a deeper level and how it is going to impact on work, which is what we were worried about. Not only our work as individuals, but our work within, where we work and the people we’re working with and the relationships we’ve developed is what we were worried about. That hasn’t been acknowledged at the senior level and so that’s poor. (ID13)

4.2.1.3.9 Organisation’s response to success and achievement in CPHC
At the pre time point, the mean response for the indicator ‘Organisation’s response to success and achievement in CPHC’ was 2.0 (SD=0.0), placing it in the Proactive category. At the interim time point, the mean response was 2.7 (SD=0.5), in the High Performing category. At the post time point, the mean response was 2.7 (SD=0.5), also in the High Performing category.

The difference between the mean scores was 0.7 (95% CI 0.4-1.0) between pre and interim time points; 0.0 (95% CI -0.5-0.5) between the interim and post time points; and 0.7 (95% CI 0.3-1.1) between pre and post time points. Participants reported significantly higher scores at the interim time point compared to the pre time point (t(11 degrees of freedom)=4.690, p=0.001, d=2.7) and significantly higher scores at the post time point compared to the pre time point (t(8 df)=4.000, p=0.004, d=2.7) (Figure 42). There was no significant difference between scores at the interim and post time points (t(19 df)=0.000, p=1.000).
In the post-program interviews, participants reported a positive impact on organisational response to success and achievement in CPHC over the 12-month period. A change in the team meeting structure was identified as a key factor that enabled the organisation to better respond to success and achievement in CPHC. However, participants highlighted that the organisation’s response was still mostly informal and could still be improved.

**Change in team meeting structure**

Changing the structure of team meetings was identified as a key factor that enabled the organisation to respond to success and achievement in CPHC. Participants found being able to share a monthly highlight with the whole team in meetings created a formal opportunity for people to share success and achievements in their work:

*Team successes and achievements are built into our meetings. I think that works really well. So when everyone goes through their highlight it’s always, ‘Wow, that’s really good,’ and it’s a team celebration, I suppose.* (ID05)

*We all do a monthly highlight when we have our team meeting. Originally it was just everyone talking about all the stuff they’ve done. Now it’s people saying one success or achievement related to CPHC. So the change in the structure of the team meetings has helped the team to celebrate what’s working well* (ID03).

**Informal organisational response to success and achievements in CPHC**

Participants highlighted that the organisation’s response to success and achievement in CPHC was still mostly informal and could still be improved. Having senior management acknowledge success and achievement in CPHC was a key recommendation:

*I think the team celebrates success but I don’t think senior management is so much involved. It’s sort of like the crew on the ground are going, ‘Yes, that’s really cool’. We will get together and say, ‘Well done’. But it’s not really higher management going, ‘Yes, that’s cool’.* (ID05)

*I guess because we’ve done so many good things as a team compared to other organisations, I think maybe the organisation takes the things we’ve done for...*
People do get recognised but there is no team celebration. People don’t know why you’re being promoted and people’s good work doesn’t get recognised from a senior level. We need more discussion and more communication from senior management about these things. (ID07)

4.2.1.3.10 Health promotion program focus

At the pre time point, the mean response for the indicator ‘Health promotion program focus’ was 1.7 (SD=0.8), placing it in the Reactive category. At the interim time point, the mean response was 2.8 (SD=0.5), in the High Performing category. At the post time point, the mean response was 2.8 (SD=0.4), also in the High Performing category.

The difference between the mean scores was 1.0 (95% CI 0.5-1.6) between pre and interim time points; 0.0 (95% CI -0.4-0.4) between the interim and post time points; and 1.1 (95% CI 0.4-1.7) between pre and post time points. Participants reported significantly higher scores at the interim time point compared to the pre time point (t(17 degrees of freedom)=3.768, p=0.002, d=1.9) and significantly higher scores at the post time point compared to the pre time point (t(14 df)=3.537, p=0.003, d=2.0) (Figure 43). There was no significant difference between scores at the interim and post time points (t(19 df)=0.141, p=0.890).
In the post-program interviews, participants reported a positive impact on health promotion program focus over the 12-month period. Three key enablers were identified: a manager with a background in health promotion; a focus on health promotion values and principles; and acknowledgement of broad health determinants.

**A manager with a background in health promotion**

Having a manager with a background in health promotion was identified as a key factor that enabled a positive impact on the health promotion program focus. Participants highlighted that having a manager drive changes in policies and processes to support a more holistic approach in health promotion enabled the change:

>You’ve got the Primary Health Care Manager who has a background in health promotion. Since she has been in that role there has been a lot of focus on working holistically and there are planning days and reporting templates to support that approach. (ID04)

**Focus on health promotion values and principles**

Focusing on health promotion values and principles was identified as a key factor that enabled a positive impact on the health promotion program focus.
Participants identified that doing specific training with a focus on health promotion values contributed to broadening the scope of health promotion programs to be more holistic:

*There has been a lot of focus on the [health promotion] values over the months and now we definitely have a holistic approach.* (ID12)

*Our professionals are seeing more holistically rather than, ‘You’ve got diabetes and let’s help you treat Type Two Diabetes’. They’re a bit more out of that disease focus. The team is more supportive of doing shared health promotion - diabetes and the physical components of that as well. It is moving more towards being holistic and I reckon this time next year it will be even better.* (ID03)

**Acknowledgement of broad health determinants**

Acknowledging the broad determinants of health was identified as a key factor that enabled a positive impact on the health promotion program focus. Participants highlighted that having an understanding of all determinants contributed to broadening the scope of health promotion programs to be more holistic:

*We use a holistic and ecological approach rather than the individual focus, we look at the person and everything around the person that impacts on their life and therefore their health rather than just looking at the one individual.* (ID11)

**4.2.1.3.11 History of health promotion in the organisation**

At the pre time point, the mean response for the indicator ‘History of health promotion in the organisation’ was 1.7 (SD=0.5), placing it in the *Proactive* category. At the interim time point, the mean response was 2.3 (SD=0.7), also in the *Proactive* category. At the post time point, the mean response was 2.7 (SD=0.5), in the *High Performing* category.

The difference between the mean scores was 0.6 (95% CI 0.0-1.2) between pre and interim time points; 0.3 (95% CI -0.2-0.8) between the interim and post time points; and 1.0 (95% CI 0.4-1.5) between pre and post time points. Participants reported significantly higher scores at the interim time point compared to the pre time point (*t*(17 degrees of freedom)=2.174, *p*=0.044, *d*=1.1) and significantly higher scores at the post time point compared to the pre time point (*t*(14
df)=3.819, p=0.002, d=1.9) (Figure 44). There was no significant difference between scores at the interim and post time points (t(19 df)=1.276, p=0.217).

Figure 44: Mean scores for Comprehensive Primary Health Care Indicator 'History of health promotion in the organisation' at pre, interim and post time points  
Note: *Significant difference between pre and interim time point scores (p<0.05) Independent Samples t test. ** Significant difference between pre and post time point scores (p<0.01) Independent Samples t test.

In the post-program interviews, participants reported a positive impact on the history of health promotion in the organisation over the 12-month period. Embedding health promotion policies and procedures into the team’s core functions was identified as a key enabler. Participants highlighted that having health promotion built into job descriptions, performance appraisals, and planning and reporting processes was a key factor that enabled a history in health promotion to be built:

*I think health promotion is definitely integrated into our core work. It’s in everyone’s program that everyone works towards it and it’s definitely well established. In terms of the team, they are getting inspired to do health promotion or have that approach in their plans and they understand it a lot more. (ID05)*

*Our job descriptions have changed quite a lot with putting health promotion in there. [For example] the expectation that our jobs are not just clinical; we have processes to follow now. We work flexibly with different groups, at times that the community needs us and all those sorts of things. Health promotion is now part of our work culture. (ID07)*

4.2.1.3.12 Attitudes towards health promotion
At the pre time point, the mean response for the indicator ‘Attitudes towards health promotion’ was 2.0 (SD=0.0), placing it in the Proactive category. At the interim time point, the mean response was 2.9 (SD=0.4), in the High Performing category. At the post time point, the mean response was 2.7 (SD=0.5), also in the High Performing category.

The difference between the mean scores was 0.8 (95% CI 0.6-1.1) between pre and interim time points; 0.2 (95% CI 0.6-0.2) between the interim and post time points; and 0.7 (95% CI 0.3-1.1) between pre and post time points. Participants reported significantly higher scores at the interim time point compared to the pre time point (t(12 degrees of freedom)=8.124, p=0.000, d=4.5) and significantly higher scores at the post time point compared to the pre time point (t(8 df)=4.000, p=0.004, d=2.7) (Figure 45). There was no significant difference between scores at the interim and post time points (t(20 df)=0.963, p=0.347).

![Figure 45: Mean scores for Comprehensive Primary Health Care Indicator 'Attitudes towards health promotion' at pre, interim and post time points](image)

Note: *** Significant difference between pre and interim time point scores (p<0.001) Independent Samples t test. ** Significant difference between pre and post time point scores (p<0.01) Independent Samples t test.

In the post-program interviews, participants reported a positive impact on attitudes towards health promotion in the organisation over the 12-month period. Three key enabling factors were identified: understanding the full
meaning of health promotion; feeling supported by management to use a health promotion approach; and the community’s response to health promotion.

**Understanding the full meaning of health promotion**

Understanding the full meaning of health promotion was identified as a key factor that enabled a positive change in attitudes towards it. Participants found learning health promotion was actually about empowering people to be in control of their health rather than disease prevention increased positive attitudes towards it:

> Health promotion is actually a holistic living and breathing thing. Whereas before I thought health promotion was something like, ‘Let’s go out there and help prevent disease’, there’s so much more to it than that. We have learnt that through our team workshops and planning days. I have so much more enthusiasm for it now. (ID13)

> I think it’s realising that we used to think health promotion was posters and brochures telling people how to be healthier. People used to think if you gave someone a brochure about their disease that was it – that was health promotion. Since we have been learning about how much more health promotion is, I think people feel a lot more encouraged by how they can use it. It can be small things they don’t have to be great, huge things, so I think people are feeling more positive about it that way. (ID03)

**Feeling supported by management to use a health promotion approach**

Feeling supported by management to use a health promotion approach was identified as a key factor that enabled a positive change in attitude towards it. Participants highlighted that being supported by management to learn about health promotion and then receive training in how to develop a program plan based on its principles and processes created a positive and supportive environment:

> I think attitudes towards health promotion are inspiring and empowering and I think that’s because of management. The manager of the Primary Health Care service has supported people to be inspired about health promotion. (ID08)

> We’re all working towards health promotion. I think some people are doing more than others and driving more than others, but we all – from what I know – feel supported. (ID04)

> I think our attitudes towards health promotion has changed quite a lot with all of the support we are getting from management - we all give it the thumbs up. (ID07)
Community response to health promotion response

The community’s response to the team using a health promotion approach was identified as a key factor contributing to a positive impact on attitudes. Participants highlighted that receiving a positive response from the community about working in a holistic rather than clinical manner helped them feel positive about the health promotion approach:

I think we’ve sort of come to agreement in some ways on understanding that CPHC and health promotion principles are the way to go because of the way we’ve seen how the community react. For example, since we have been focusing on improving access to our services, I’ve just seen so many people respond to being picked up at home or being visited at home. I think that’s a really big thing. Also another thing, I think the community understanding how broad we can go, of how it’s not just all about meeting at the clinic. I’ve seen a lot of attendance to things that are outside of the clinic and a lot more willingness, a lot more smiles when it’s not at the clinic. (ID10)

A lot of things have improved since we have been using health promotion. I’ve been able to create such a good rapport with people through doing community groups and sessions outside of the clinic. This has had a flow-on effect to actually increase the amount of patients coming to see us. (ID08)

It’s great to see all the links being made through using health promotion. For example, the dietitian is doing some new food store programs. That is pretty cool because there is no point in her sitting in the clinic and telling people about the healthy food they should be eating if they can’t even buy it at their local store. If people’s nutrition needs are looked at, all our jobs are made easier. (ID06)

4.2.1.3.13 Summary of results for sub-question three

Research sub-question three asked: What is the impact of a CPHC ODS on FNQRDGP’s organisational culture? From the pre to post time points, nine of the 12 indicators of organisational culture had statistically significant increases, indicating movement in a positive direction towards increasing FNQRDGP’s capacity to deliver CPHC (Table 18). Two of the indicators shifted from Reactive to High Performing and seven shifted from Proactive to High Performing.

Within the Overall view of the organisation sub-component, six of the nine indicators had significant increases, with one shifting from Reactive to High Performing and five from Proactive to High Performing. All three indicators within the Health promotion culture sub-component had significant increases, with one shifting from Reactive to High Performing and two from Proactive to High Performing.
Key enablers identified as being necessary to increase FNQRDGP’s capacity to deliver CPHC were: 1) dedicated management position to lead CPHC teams; 2) managers with health promotion background and acknowledgement of broad health determinants; 3) whole-of-team understanding about how to apply health promotion to enable CPHC practice; 4) whole of team professional development opportunities with a focus on health promotion and CPHC values and principles; 5) whole-of-team CPHC reflective opportunities; and 6) being listened to and valued by management by being trusted to use initiative and respected as a professional – feeling empowered and able to make a difference.

Key barriers identified as limiting FNQRDGP’s capacity to deliver CPHC were: 1) not having a whole-of-organisation process to be accountable to the communities identified priorities; and 2) changes in the external environment that can impact negatively on morale.

Table 18: Research sub-question three quantitative results summary

<table>
<thead>
<tr>
<th>CPHC ODS Component</th>
<th>CPHC ODS sub component</th>
<th>Indicators</th>
<th>Time point: Pre – Post</th>
<th>t</th>
<th>P</th>
<th>d</th>
<th>Categorical change*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisational Culture</td>
<td>Overall view of the organisation</td>
<td>26. Mission and Strategy</td>
<td>2.980</td>
<td>0.011</td>
<td>1.8 (L)</td>
<td>P-HP</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>27. Strategic Direction</td>
<td>5.216</td>
<td>0.000</td>
<td>2.9 (VL)</td>
<td>P-HP</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>28. Level of care</td>
<td>7.000</td>
<td>0.000</td>
<td>5.3 (NP)</td>
<td>P-HP</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>29. Focus of activity</td>
<td>3.578</td>
<td>0.003</td>
<td>1.8 (L)</td>
<td>P-HP</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>30. Accountability</td>
<td>1.936</td>
<td>0.075</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>31. Morale</td>
<td>0.974</td>
<td>0.346</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>32. Organisational values</td>
<td>4.094</td>
<td>0.001</td>
<td>2.0 (VL)</td>
<td>R-HP</td>
<td></td>
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<td></td>
<td></td>
<td>33. Organisation’s response to change</td>
<td>0.633</td>
<td>0.536</td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td>34. Organisation’s response to success and achievement in CPHC</td>
<td>4.000</td>
<td>0.004</td>
<td>2.7 (VL)</td>
<td>P-HP</td>
<td></td>
</tr>
<tr>
<td>Health promotion culture</td>
<td>35. Health promotion program focus</td>
<td>3.537</td>
<td>0.003</td>
<td>2.0 (VL)</td>
<td>R-HP</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>36. History of health promotion in the organisation</td>
<td>3.819</td>
<td>0.002</td>
<td>1.9 (L)</td>
<td>P-HP</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>37. Attitudes towards health promotion</td>
<td>4.000</td>
<td>0.004</td>
<td>2.7 (VL)</td>
<td>P-HP</td>
<td></td>
</tr>
</tbody>
</table>

* S=small, M=medium, L=large, VL=very large, NP=nearly perfect
** R-P = mean score for indicator changed from Reactive category to Proactive category, P-HP = Proactive to High Performing, R-HP = Reactive to High
4.2.2 Overall research question results

The research question asked: What is the impact of a CPHC ODS on the capacity of FNQRDGP to deliver CPHC? From the pre to post impact evaluation time points, 31 out of the 37 indicators had statistically significant increases, with effect sizes for the increases ranging from moderate to nearly perfect. The majority of indicators had large or very large increases. Twenty nine (78%) of the indicators had significant increases from a lower category at the pre time point to the High Performing category at the post time point. Twelve of the indicators (32%) shifted from Reactive to High Performing, two (5%) shifted from Reactive to Proactive and 17 (46%) shifted from Proactive to High Performing. These results indicate that the CPHC ODS increased FNQRDGP’s capacity to deliver CPHC.

Key enablers identified as being necessary to increase FNQRDGP’s capacity to deliver CPHC were: 1) dedicated leadership for CPHC teams with experience in and commitment to CPHC practice; 2) managers with health promotion background and acknowledgement of broad health determinants; 3) CPHC values and principles embedded in all aspects of the organisation’s functions; 4) health promotion theory and resources embedded within all areas and levels of the organisation; 5) whole of team professional development opportunities with a focus on health promotion and CPHC values and principles; 6) whole-of-team understanding about how to apply health promotion to enable CPHC practice; 7) dedicated whole-of-team time to reflect and evaluate organisation’s actions across CPHC continuum; 8) value for and support to conduct community engagement processes; 9) team structure reflects horizontal network compared to a hierarchical structure; 10) being listened to and valued by management by being trusted to use initiative and respected as a professional – feeling empowered and able to make a difference.

Key barriers identified as limiting FNQRDGP’s capacity to deliver CPHC were: 1) not having a whole-of-organisation process to be accountable to communities’ identified priorities; 2) guidelines and deliverables attached to program funding; 3) competitive nature of funding between health services;
4) changes in the external environment that can impact negatively on morale; and 5) partnerships with key stakeholders that are not based on CPHC values and principles.

4.3 Conclusion

This chapter presented the research results. It provided a description of the participants and changes in FNQRDGPs’s capacity to deliver CPHC over the 12-month period of the CPHC ODS implementation. Changes in FNQRDGPs’s capacity to deliver CPHC were presented in two sections. The first section was organised in three parts around each of the research sub-question results. Quantitative and qualitative results for each of the CIF’s 37 indicators across the three time points were reported. Each part concluded with a summary of the results for each research sub-question. The second section reported results for the overall research question pre and post implementation of the CPHC ODS.
5.0 Discussion

This chapter discusses the research results. Results are discussed in relation to the literature and the three components of the CPHC ODS: 1) workforce development; 2) organisational processes; and 3) organisational culture. A range of enablers and barriers within and across the three components that impact on an organisation’s capacity to deliver CPHC are identified. A summary of discussion findings for each CPHC ODS component is provided.

5.1 Comprehensive Primary Health Care Organisational Development Strategy

The research results demonstrate that the Comprehensive Primary Health Care Organisational Development Strategy (CPHC ODS) had a positive impact on the capacity of FNQRDGP to deliver CPHC including: workforce development processes, organisational processes, and organisational culture. Almost all of the statistically significant increases in indicators resulted in shifts to the High Performing category, with large to very large effect sizes. A number of key enablers and barriers to these shifts were identified and are discussed in reference to related quantitative results with very large to nearly perfect effect sizes and the literature. Quantitative results are not discussed in reference to the literature due to there being no identified studies that have reported quantitative impact evaluation findings.

5.1.1 Workforce development component

All five indicators of the workforce development component had statistically significant increases. Three of the indicators moved from Reactive to High Performing and two moved from Proactive to High Performing, with large or very large effect sizes. Three enablers to develop workforce capacity to deliver CPHC were being able to conduct CPHC, having CPHC direction and support, and human resource systems. Several of these enablers were consistent with those identified in the literature.
5.1.1.1 Being able to conduct CPHC

The research identified that in order to deliver CPHC staff must first be able to conduct CPHC. Enablers identified in relation to staff feeling able to conduct CPHC were: leadership style and health promotion resources. Leadership styles identified were: enthusiastic and passionate about CPHC; committed to CPHC philosophy, empowering and inspirational to motivate long term gains in CPHC practice; and compassionate and empathetic for community and staff needs. Leadership styles were identified as important because a manager’s belief and conduct about CPHC ‘flowed onto’ their team members and influenced how supported and motivated team members felt to deliver CPHC.

The importance of leadership style is also highlighted in the literature whereby performance in health services is strongly linked to leadership style. Reasons for reorientation strategies failing in the past have been attributed directly to management’s lack of leadership to drive the change process. Baum et al. and Heward et al. found that when managers do not embody the change principles they expect of their teams, they run the risk of staff disengaging from the change process. Johnson and Paton state that when leading an organisational development strategy managers must be the change they want to see in their staff. They explain that managers must inspire change by leading as a ‘change agent’ and empower everyone around them to do the same.

These results for leadership style indicate it is important for managers to reflect the change they want to see to ensure staff remain engaged in and feel supported through the change process.

Research results identified that in order for staff to be able to conduct CPHC access to adequate health promotion resources are required. A high value was placed on having direct access to qualified Health Promotion Practitioners (HPPs). Positioning HPPs within the team of allied health professionals was considered more useful to enable CPHC delivery than HPPs working on separate programs in isolation from other team members. The need for a more integrated whole-of-team approach to health promotion within and across health
services is also supported by the World Health Organisation (WHO),
government departments, professional associations and public health
researchers. The need to reorient (health) services to make health promotion
everyone’s business is clearly articulated in the Ottawa Charter for Health
Promotion\textsuperscript{47} and WHO’s settings approach to health promotion.\textsuperscript{131} While some
health services have taken this to mean that they do not need specific HPPs if
health promotion is everyone’s business, others have advocated for WHO’s
initial intentions. For example, the Victorian Government Department of Health
Services\textsuperscript{71} published a report in 2003 detailing the clear need for specific health
promotion roles to support an integrated approach to CPHC delivery. One of the
key recommendations was to have dedicated HPPs to facilitate and coordinate
the planning, implementation and evaluation of programs within and across
program areas.

Re-shaping the HPP role to facilitate and coordinate the development,
implementation and evaluation of discipline-specific health promotion programs
was identified in this research as an important change that enhanced
FNQRDGP’s capacity to deliver CPHC. It was considered an important change
because working with HPPs increased staff members understanding and
confidence about how their specific discipline could deliver CPHC through
health promotion strategies and action areas. Employing HPPs and positioning
them within clinical teams to support CPHC and health promotion delivery is
consistent with ideas presented by Heward \textit{et al.}\textsuperscript{26}, Moulton \textit{et al.}\textsuperscript{24} and New
South Wales Health.\textsuperscript{73} They agree with the need to position HPPs through
multiple levels of an organisation to enhance whole-of-team capacity to deliver
CPHC. NSW Health emphasise this is a key ingredient in the capacity building
mix.\textsuperscript{73}

Research results also identified that having HPPs facilitate and coordinate a
team’s health promotion processes (needs assessment, planning,
implementation and evaluation) increased understanding about HPPs skill set
and function within a health service. When HPPs worked separately from the
allied health team staff did not understand what HPPs were employed to do or
have a full appreciation of their skill set. This level of overall understanding
about how HPPs can support health services to reorient to CPHC is consistent with Baum and Sanders\textsuperscript{34}, Lopez \textit{et al.}\textsuperscript{70} and Yeatman and Nove\textsuperscript{68} who posit that the potential of health promotion as a strategy to reorient health services to deliver CPHC has remained largely untapped by health services around the world. This is irrespective of the call from the WHO for the application of health promotion strategies and action areas to support reorientation to CPHC for thirty years in several of its policy directions and initiatives.\textsuperscript{1-8, 47, 48, 131, 132}

Results for health promotion resources indicate that HPPs need to be positioned more purposefully within health services to support the development of health promoting skills within and across the organisation to support reorientation to CPHC. This result indicates the potential need for further advocacy to increase understanding about the need for HPPs to be placed in all health related services, particularly in Divisions of General Practice to support the transition to PHC Organisations commencing in 2011.

\textbf{5.1.1.2 Having CPHC direction and support}

The research results identified that in order to deliver CPHC staff require direction and support from their organisation. This is consistent with other researchers who highlight that the reason several reorientation strategies have limited impact is because the organisation does not provide enough, or the right kind of direction and support for staff to deliver CPHC.\textsuperscript{17, 23-25, 28, 68, 87} Specific enablers identified in the research that contributed to FNQRDGP developing direction and support for CPHC were understanding \textit{how} to apply CPHC and health promotion knowledge, a continuum of professional development opportunities, and a dedicated position to direct and support the reorientation process.

Research results indicated that understanding \textit{how} to apply CPHC and health promotion knowledge was an important aspect of workforce development. Investment in team knowledge about \textit{how} to deliver CPHC is supported by NSW Health\textsuperscript{73} and Keleher \textit{et al.}\textsuperscript{80} who recognise the importance of developing staff knowledge and understanding around \textit{how} CPHC and health promotion
can be applied in everyday practice. They explain that increasing levels of knowledge about what CPHC and health promotion are is the first stage of building workforce capacity. For this capacity to be maximised, the next stage is for the workforce to understand how to apply knowledge in practice. Johnson and Paton\textsuperscript{25} agree and state that it’s all well and good to have knowledge about CPHC and health promotion but not knowing how to apply it to everyday practice means service delivery and therefore health outcomes will not change. Baum\textsuperscript{30} supports this notion that people who work in public health should not just aim to understand but to use that understanding to bring about change.

Several public health researchers have advocated the need for health services to move beyond the rhetoric of CPHC philosophy,\textsuperscript{8, 11, 18, 20, 22, 40, 41, 82, 133} yet few have explained how to operationalise CPHC into everyday practice. This may help to explain the limited uptake of CPHC over the last thirty years.

These research results and literature indicate the need for health services to invest in workforce development that supports health professionals to learn how to translate CPHC philosophy into their discipline-specific practice.

The research results determined an effective way to provide CPHC direction and support was to provide a range of informal and formal professional development opportunities for individuals through to whole-of-team. Results identified developing a continuum of opportunities enabled staff to self select what best suited preferred learning styles and needs, and therefore maximised CPHC and health promotion learning outcomes. NSW Health\textsuperscript{73} also recognise the significance of offering a continuum of professional development opportunities to build individual through to whole-of-team capacity in health promotion.

Research results demonstrated the increase of whole-of-team professional development opportunities was identified as important to: experience common learnings about CPHC and health promotion; understand how each discipline contributed to the delivery of CPHC; identify opportunities for an integrated CPHC team approach; and critically reflect on how the whole team was progressing CPHC delivery. Dunbar \textit{et al.}\textsuperscript{95} recognise the importance and
advantage of operating as a whole team to deliver CPHC. They explain that CPHC as a philosophy is about an integrated approach to improve health care delivery for its consumers. They state this should therefore mean organisations need to develop processes and systems that support the whole team to plan integrated health care delivery.

The results also identified that in developing whole of team professional development opportunities, it is equally important to work with staff to progress individual learning needs. Using the recruitment process and performance appraisals was recommended as a way for managers to ensure individual professional development was supported. A key point emphasised in both the research results and literature is the need to develop a culture that supports ongoing formal and informal professional development opportunities for individuals and the whole team. Heward et al.\textsuperscript{26} and Johnson and Paton\textsuperscript{25} emphasise that for investments in CPHC and health promotion professional development to be maximised, it is important that staff members are supported in an ongoing learning culture. The benefits of attending one-off professional development opportunities are limited if the organisational culture they return to does not support continued learning. Strategies to support ongoing CPHC and health promotion learning identified as being useful in the research results and literature include: CPHC email list serves; critical reflection templates; access to external workshops, conferences and courses; regular whole-of-team training and planning days; regular discipline-specific CPHC in-services; regular whole-of-team reflection processes to encourage an integrated CPHC approach; visual prompts in the office that display the CPHC continuum and the Ottawa Charter for Health Promotion action areas and strategies; regular meetings with HPPs to discuss the development, implementation and evaluation of discipline-specific health promotion programs.\textsuperscript{17, 23-25, 68, 71, 73, 80, 84, 88, 92, 95, 100, 130}

Results for professional development opportunities suggest that investment in workforce development that supports health professionals to learn how to translate CPHC philosophy into their discipline-specific practice is useful. In addition to this, results indicate that developing a continuum of individual and
Impact evaluation of a CPHC ODS on a health service’s capacity to deliver comprehensive primary health care

whole-of-team professional development opportunities both formal and informal is useful.

The research results determined an effective way to provide CPHC direction and support was to have a management position dedicated to the reorientation and organisational development process. These results are consistent with findings presented by Johnson and Paton and Rogers and Veale who emphasise the need to recognise that managing organisational change is a highly complex task and therefore requires dedicated resources. Johnson and Paton state several health services have underestimated the complexity of the change and under resourced the process. They caution that planned change will not happen unless there is someone to lead and manage the process. They suggest an organisation needs to consider ‘Who is going to manage the process of diagnosing the existing situation in the organisation?’ ‘Who is going to facilitate the visioning process?’ ‘Who is going to analyse resistance?’ All of the tasks identified in the change process need to be managed, completed and coordinated by someone. The research results are also consistent with findings by Doyle et al. who posit that good change management processes require dedicated management resources and structures to be in place. They agree that change management processes and activities need to be managed by some individual or group.

These research results and literature suggest that having a dedicated individual or a group to lead and manage the CPHC reorientation is important to consider in the reorientation process.

5.1.1.3 Human resource systems
The research results identified developing workforce capacity through human resource systems was an effective way to enhance workforce capacity to deliver CPHC. Results demonstrated it was beneficial to develop processes that linked all stages of the employment cycle to CPHC and health promotion guidelines. For example, starting at the recruitment stage interview questions should reflect the CPHC and health promotion nature of the position detailed in discipline-specific job descriptions. Job descriptions then provide discipline-
specific duties and responsibilities related to working across the full CPHC continuum. Planning and reporting templates should reflect the full scope of discipline-specific duties and responsibilities to achieve CPHC and used to guide discussions in feedback meetings and performance appraisals. The usefulness of including CPHC duties and responsibilities and performance indicators in job descriptions and performance appraisals were reflected in the quantitative data, with both indicators showing very large effect sizes.

Workforce capacity building programs conducted by NSW Health\textsuperscript{73, 84} placed a high value on developing clear processes and guidelines to support both employers’ and employees’ understanding about how they are expected to contribute to health promotion delivery. They found that when clear guidelines were developed from the start of the recruitment phase, feedback processes such as performance appraisals offered both the employer and the employee the opportunity to learn from each other about how workforce capacity to deliver health promotion can continue to be strengthened. This outcome is consistent with the findings of this research.

Research results also found it was important for staff members to be involved in the re-development of duties and responsibilities listed in job descriptions to align with CPHC. Dedicated reflection time to support the redevelopment of job descriptions was highly valued and contributed to staff understanding why the changes were necessary. Results showed that being involved in the change was empowering for staff and helped them feel connected to the process. These results are supported in both the organisational change and public health literature. Several researchers recognise the importance of involving the people who are impacted by the change in the change.\textsuperscript{17, 25-27, 70, 76, 88, 97, 135} Baum,\textsuperscript{30} Hawe \textit{et al.}\textsuperscript{117} and Wass\textsuperscript{28} all agree that when managing change it is critical to use participatory processes that work \textit{with} the people rather than \textit{on} them, otherwise long term commitment to and sustainability of change is at risk.

These results demonstrate that including staff in the development of human resource processes that link all stages of the employment cycle to CPHC and health promotion guidelines had a significant impact on FNQRDGP’s capacity to
deliver CPHC, therefore could be useful to include in service reorientation processes.

5.1.2 Organisational processes
Seventeen of the twenty indicators of the organisational processes component had statistically significant increases. Seven of the indicators moved from Reactive to High Performing, eight moved from Proactive to High Performing, and two moved from Reactive to Proactive, with medium to very large effect sizes. Four enablers that enhance organisational processes to support CPHC delivery were supportive organisational infrastructure, team re-structure, policies and procedures, and management and human resource practices. Several of these were consistent with those identified in the literature.

5.1.2.1 Supportive organisational infrastructure
Results indicated that supportive organisational infrastructure was required to increase FNQRDGP’s capacity to deliver CPHC. Specific enablers identified in the research that contributed to FNQRDGP developing supportive organisational infrastructure were: a clear strategic direction; a dedicated management role to lead the organisational development strategy; whole-of-team professional development opportunities; people with experience and skills in health promotion through multiple levels of the organisation; planning and reporting processes that reflect CPHC and health promotion; and systems that support CPHC and health promotion delivery. Indicators related to FNQRDGP’s strategic direction and systems to support health promotion both had very large changes between pre and post CPHC ODS implementation.

These results are consistent with findings of other researchers who acknowledge that a health service must have supportive infrastructure to enable CPHC and health promotion practice. Johnson and Paton and Heward et al. recognise that health services may employ several health professionals who understand CPHC and health promotion. However, in order for them to apply knowledge to everyday
practice in a meaningful way, the organisation must have infrastructure to support CPHC and health promotion action. These results and the literature suggest that developing supportive organisational infrastructure is important to increase an organisation’s capacity to deliver CPHC.

5.1.2.2 Team re-structure
The research demonstrated that an important organisational process that impacted on capacity to deliver CPHC was the team re-structure. Having a manager with a background in health promotion and HPPs positioned across the allied health teams was conducive to delivering CPHC. Johnson and Paton25 and NSW Health73, 84 agree that strategically positioning people with health promotion experience and skills across multiple levels of a health service is an important enabler to increase overall capacity to deliver CPHC.

Results indicated that developing a team structure supportive of health promotion processes also grows a strong culture of quality improvement within a health service. Using health promotion processes: needs assessment; planning; implementation; and evaluation (process, impact and outcome) ensure quality improvement cycles are continuous and ongoing. This result is consistent with ideas presented by Wadsworth,124 Nutbeam and Bauman123 and Hawe et al.117 who suggest that health promotion processes support continuous quality improvement cycles.

These results and literature demonstrate that positioning people with health promotion experience and skills across multiple levels of a health service may help to increase a health services’ overall capacity to deliver CPHC. Health promotion processes may also support organisations in their continual and ongoing quality improvement.

5.1.2.3 Policies and procedures
Results found that policies and procedure are a practical mechanism that health services can use to operationalise CPHC philosophy into daily practice. Specific
policies that were considered useful to enhance CPHC and health promotion practice were: health promotion is everyone’s core business; discipline-specific time allocations for clinical and health promotion activity; and reporting against action plans that incorporate the Ottawa Charter for Health Promotion action and strategy areas, and the full CPHC continuum. Indicators related to this had very large changes between pre and post CPHC ODS implementation.

These findings are consistent with the WHO’s recommendation to use the Ottawa Charter’s strategy and action areas to reorient health services to move beyond clinical level care to CPHC. Researchers increasingly recognise health promotion as a useful discipline that can provide practical strategies for health services to operationalise CPHC. Baum, Wass, the Victorian Government Department of Health Services and the International Network for Health Promoting Hospitals and Health Services recognise the practical foundation the Ottawa Charter offers health services to translate CPHC philosophy into everyday practice for a range of health professionals. The International Network for Health Promoting Hospitals and Health Services emphasises the advantage of developing organisational processes based on the Ottawa Charter strategy and action areas. They suggest that health services can apply health promotion action at multiple organisational levels, from senior management planning through to health professionals delivering CPHC services. Ottawa Charter strategy and action areas can also act as a check-list to ensure practice reflects a range of change strategies that will contribute to long-term and sustainable CPHC practice, which in turn will lead to improved health outcomes.

Results and literature suggest that developing policies and procedure based on health promotion may be practical mechanisms to operationalise CPHC philosophy into daily practice, and therefore increase health services’ capacity to deliver CPHC.

One of the strong findings to emerge from this research was that dedicated time to reflect on team and individual CPHC performance and related change processes had an impact on increasing FNQRDGP’s capacity to manage
change and deliver CPHC. Whole-of-team gatherings that provided dedicated time to critically reflect on progress towards achieving program goals and objectives aligned with CPHC were considered useful. Indicators related to this had very large changes between pre and post CPHC ODS implementation.

This finding is consistent with a large body of literature that supports the notion of reflective practice to improve and develop evidence-based outcomes. White et al.\(^\text{138}\) state that critical reflection in professional practice is becoming increasingly popular across the health professions as a way of ensuring ongoing scrutiny and improved concrete practice. When critical reflection is conducted with all team members it can be a transformative process that enables skills to be transferred across disciplines.\(^\text{138}\) Johnson and Paton\(^\text{25}\) and Doyle et al.\(^\text{134}\) also posit that critical reflection enables practitioners and managers to develop both individual and whole-of-team learning capacity.

Results and literature indicate that using critical reflection tools to support whole-of-team reflection time can increase an organisation’s capacity to learn from and strengthen CPHC practice.

Not having a formalised organisational community engagement procedure in place was identified as a barrier to building organisational capacity to deliver CPHC. Research results identified that an important principle of CPHC philosophy is to work with community identified priorities, yet staff members felt this process was limited because no formalised procedure to do this was in place. Literature emphasises the importance of having health services develop structured community engagement procedures to ensure quality engagement processes take place.\(^\text{11, 28, 31, 117}\)

This highlights an area for continued advocacy for health services that rely on external funding. Research results demonstrated that health services are often limited to expand their community engagement processes because program deliverables are pre-determined by funding bodies. This is a common concern for health services that want to engage in CPHC practice but cannot carry out
the crucial component of working with community-identified priorities due to external program deliverables imposed on services by funding bodies.6, 8, 11, 18, 87

5.1.2.4 Management and human resource practices
The research results identified management and human resource practices that had both positive and negative impacts on the organisation’s capacity to deliver CPHC. Practices that had a positive impact on capacity to deliver CPHC included: management’s broad understanding of health determinants; investments in long term health outcomes versus short term monetary gain; the flexibility for staff members to share resources with other health services to enable CPHC outcomes; acknowledgement that both qualitative and quantitative reporting was necessary to capture a full account of service delivery impact; value for a multidisciplinary integrated approach to achieve health outcomes; development of processes to create a supportive learning and working environment to achieve CPHC; and inclusive and participatory processes in the change process.

These enablers are supported by findings in the literature. In particular, Johnson and Paton25 support the finding that inclusive and participatory processes are critical to increase capacity to deliver CPHC as well as sustain the change process. They identify inclusive and participatory processes as important because they are the fundamental principles of CPHC and health promotion. They state that any change process should be conducted to allow as many staff members as possible to develop it. A shared vision for change is likely to generate the highest degree of commitment, help to overcome resistance, and avoid the danger of poor sustainability owing to limited involvement in the change process.25

These results and literature suggest that when management use participatory and inclusive change processes it is likely to have a positive impact on staff members’ commitment to and engagement with an organisation’s reorientation to CPHC.

Practices that had a negative impact on the organisation’s capacity to deliver CPHC were collaboration with partners who did not understand CPHC and
inconsistencies between senior and middle management practices. Research results identified that staff members found it difficult to collaborate with services that did not understand CPHC philosophy. Staff members felt it was potentially more beneficial to focus ‘inwards’ to first strengthen the organisation’s own CPHC practice before working with services who ‘watered down’ their CPHC practice.

These results suggest it may be useful for a health service to focus firstly on strengthening its own internal CPHC practices rather than attempting to work with all services and agencies that have potential impact on CPHC delivery.

Inconsistencies between senior and middle management was identified as a barrier to develop organisational capacity to deliver CPHC services in this research. Staff members felt that senior management were not as committed to CPHC practice as middle management. Burke\textsuperscript{88} and Kotter\textsuperscript{139} show that differences in levels of commitment between senior and middle management will impact on the effectiveness and long term sustainability of the change process. Opportunities to present CPHC and health promotion progress to the board was suggested in this research as a possible strategy to bridge the gap between senior and middle management’s commitment and understanding of CPHC. This is supported by Wass\textsuperscript{28} who states that because CPHC focuses on long-term changes that are not always immediately evident, it is important that ‘small wins’ are celebrated to ensure staff members feel valued by management for the steps they are making towards achieving CPHC.

The results and literature indicate that developing a formal rewards and recognition program to demonstrate senior management value for CPHC team work and achievements could have a positive impact on an organisation’s capacity to deliver CPHC. Developing consistent levels of middle and senior management commitment to CPHC reorientation process was also considered important.

5.1.3 Organisational culture

Nine of the twelve indicators of the organisational culture component had significant increases. Two of the indicators moved from Reactive to High
Performing and seven moved from Proactive to High Performing, with large to nearly perfect effect sizes. Two enablers to support CPHC delivery were supportive organisational infrastructure and management conduct grounded in values and principles that reflect CPHC philosophy. These were consistent with enablers identified in literature.

5.1.3.1 Supportive organisational infrastructure

The research results identified developing organisational infrastructure that supports staff members to deliver CPHC and health promotion had a positive impact on the organisation’s culture. Contributing enablers identified in the research were: a planned response to underlying determinants of health through discipline-specific health promotion action plans rather than ad hoc reactions that do not address determinants; whole-of-team professional development opportunities; and a reflective learning approach to CPHC practice.

Results demonstrated that staff understanding about how their specific discipline contributed to the underlying determinants of health and how they could make a positive difference to change, significantly impacted on job satisfaction, morale, and feelings of empowerment. Using the Ottawa Charter for Health Promotion strategy and action areas, and the CPHC continuum to inform planned responses to underlying health determinants was identified as an effective strategy for staff to understand how they could contribute to meaningful change. Explicit focus on how CPHC and health promotion values and principles could be applied in practice through training and planning days was identified as motivating, inspiring and empowering. Staff members identified a significant shift in their capacity to deliver CPHC to include individual, community and population level care, reflective of the full CPHC continuum. The indicator related to level of care being provided had the largest effect change, nearly perfect, out of the 37 indicators.

This result is consistent with findings in the literature that refer to the high rate of ‘burn out’ and ‘fatigue’ in professionals who work tirelessly in the health sector with little evidence of change.\textsuperscript{10, 11, 28, 29, 95, 133, 140} WHO acknowledges that health is created outside of the health system and therefore to contribute to...
change health services must support staff members to design planned responses that address the broader range of interrelated political, social, economic, cultural and physical environmental determinants of health.\textsuperscript{1, 2, 4, 8, 47, 48} Without this insight, health services are at risk of high staff turnover and understaffed facilities, which are evident in Australia’s health care system.\textsuperscript{9, 10, 104}

Results and literature could indicate that developing discipline-specific planned responses that address the broader range of interrelated determinants of health could help increase staff morale, job satisfaction and feelings of empowerment.

Whole-of-team professional development opportunities were identified as an effective way to increase understanding about how individual disciplines within the team contributed to CPHC delivery. Results identified staff members felt more valued and appreciated by colleagues and management as a result of having more whole-of-team gatherings and reflection sessions. This is consistent with Buke\textsuperscript{88} and Kotter\textsuperscript{139} who agree with the importance of acknowledging each team member’s contribution to achieving mutual goals in a team setting. They explain it contributes to the development of a culture that respects and values interdisciplinary diversity. This finding also aligns with the holistic, ecological and salutogenic paradigm that underpins CPHC and health promotion, wherein the whole is greater than the sum of its individual parts.\textsuperscript{12, 16, 38}

These results may suggest that aligning organisational practices and change processes with CPHC’s underlying paradigm will enable the development of an organisational culture that drives and sustains CPHC practice.

\textbf{5.1.3.3 Management interactions grounded in values and principles that reflect CPHC philosophy}

The research results identified that management interactions grounded in values that reflect CPHC philosophy had a positive impact on the organisation’s culture. Contributing enablers identified in the research were: using participatory and inclusive processes; respecting staff members for the individual value they contribute to the team achieving CPHC; developing an open and flexible
learning environment; supportive reflective practice; fair and transparent processes; and explicit change strategies that reflect CPHC values and principles. These results are consistent with findings by Johnson and Paton,\textsuperscript{25} Senge,\textsuperscript{141} Dixon\textsuperscript{142} and Cohen and McDaniel\textsuperscript{143} who recognise that management interactions must align with CPHC values to support an authentic learning and change experience. Johnson and Paton\textsuperscript{25} agree that management need to demonstrate how their interactions align with CPHC learning and change principles and recommend practical strategies for this to take place: for example regular reviews of experiences for the change agents; providing change agents with mentors; encouraging and facilitating electronic networking with other change agents in other organisations; and providing regular reports and presentations on progress.

Results also indicated that the way the change process was managed had a significant impact on the organisation’s capacity to deliver CPHC. Results suggest that the style of change management determined the way staff members felt about the change and determined whether or not they would engage in the process. It was evident that staff members placed high value on change management strategies that were underpinned by values and principles that were consistent with the CPHC direction of change. Important change management values and principles that were identified were: participation and inclusion in decision and planning processes; empowerment of staff members to feel they could contribute to meaningful and long-term change; respect for the skills and experience that individuals bring to a team; critical reflection on practice; honesty and openness about how systems and CPHC practice could be improved; and evidence based approaches.

These findings are consistent with Johnson and Paton\textsuperscript{25} who agree that a values-based approach to change management is important in the health sector. They state that to bring about change in health care, the processes and approaches employed must reflect the values bases of the type of organisation you wish to create. They explain that there is something fundamentally flawed and hypocritical about trying to create a health service that enhances health and
well-being if the processes used to create that organisation do not reflect its organisational values. These results and literature may suggest that when health services align change strategies with the same CPHC values and principles they are aiming to achieve in practice, sustained capacity to reorient to CPHC is likely.

A barrier that had a negative impact on organisational culture was the difference between middle and senior management’s conduct reflecting CPHC values and principles. Results indicated that when a difference between middle and senior management conduct is identified it creates concern that teams are operating from an inconsistent values base within the organisation. In effect, it creates a divide between middle and senior management which is not conducive to the whole organisation delivering CPHC. It was recognised that senior management’s values and principles did not align with CPHC because there was no change to the organisation’s values and mission statement. Literature supports the importance of the organisation’s value and mission statement reflecting CPHC values and principles to demonstrate genuine commitment to CPHC practice.²⁵, ⁸⁸, ¹⁴³

These results and literature suggest senior and middle management need to have a consistent CPHC values-based approach to manage change for reorientation strategies to be sustainable.

5.1.4 CPHC ODS component discussion summary
This research assessed the impact of 37 CPHC capacity indicators across the three components of the CPHC ODS: 1) workforce development; 2) organisational processes; and 3) organisational culture. Findings from this research and literature indicate that a range of enablers and barriers within and across the three components have the potential to impact on an organisation’s capacity to deliver CPHC. A summary of the discussion related to the enablers and barriers for each CPHC ODS component is provided below.

To develop workforce capacity to deliver CPHC it is important that Managers reflect the change they want to see to ensure staff remain engaged in and feel
supported through the change process. It is also important that Health Promotion Practitioners (HPPs) support other health professionals to understand how to translate CPHC philosophy into discipline-specific practice. A continuum of individual and whole-of-team professional development opportunities, both formal and informal was highlighted as a mechanism for supporting a range of learning styles which may in turn increase workforce capacity to deliver CPHC. It is also useful to develop human resource processes that link all stages of the employment cycle to CPHC and health promotion guidelines. Finally, developing policies and procedure based on health promotion strategy and action areas can be an effective way to support workforce development in CPHC.

To develop organisational processes to deliver CPHC it is important to dedicate an individual or a group to lead and manage the CPHC reorientation process is this is more likely to enhance effectiveness and sustainability of reorientation efforts. Positioning people with health promotion experience and skills across multiple levels of a health service may also be useful to increase overall capacity to deliver CPHC. Using health promotion processes, for example, : needs assessment; planning; implementation; and evaluation can support continuous and ongoing quality improvement cycles for the whole organisation. Using health promotion action and strategy areas to develop policies and procedures provides a practical mechanism to enhance organisational processes that support CPHC delivery. Lastly, developing structured community engagement procedures to ensure quality engagement processes take place may support capacity to deliver CPHC.

To develop an organisational culture that supports CPHC it is important to dedicate whole-of-team time to reflect on team and individual CPHC performance and change processes that may enhance capacity to deliver CPHC. Using participatory and inclusive change processes is an effective way to involve as many staff members as possible in developing change which may lead to increased commitment and enthusiasm for change. Developing discipline-specific planned responses that address the broader range of interrelated health determinants can support staff to feel empowered to make a
difference. It is also important to align organisational practices and change processes with CPHC’s underlying holistic, ecological and salutogenic paradigm. This may enable the development of an organisational culture that drives and sustains CPHC practice. Changing the organisation’s value and mission statement to reflect CPHC values and principles may help to demonstrate genuine commitment to CPHC practice. Aligning change strategies with CPHC values and principles may support effectiveness, sustainability and commitment to the CPHC ODS.

In addition, the development of an organisational culture that support CPHC delivery required the development of formal rewards and recognition programs which may help to demonstrate senior managements' value for a CPHC teams’ work and achievements. Developing consistent levels of middle and senior management commitment to the CPHC reorientation process may be beneficial for staff commitment engagement with the change process. Celebrating 'small wins’ may be an effective way to ensure staff members feel valued by management for the steps they are making towards achieving CPHC. Acknowledging each team member’s individual contribution to whole-of team CPHC delivery may also be important in increasing job satisfaction and staff morale. Publicly demonstrating respect and value for interdisciplinary contribution to CPHC delivery may also further enhance the development of an integrated team approach. Finally, aligning managements’ interactions with CPHC values and principles may support an authentic CPHC learning and change experience.

5.3 Research design
This section of the discussion reflects on the positioning of the research within a constructivist epistemology, the critical theory theoretical perspective and evaluation research methodology.

Constructivist epistemology was appropriate for the research because it enabled the researcher to construct knowledge about the participants’ perceptions and experiences of changes in FNQRDGP’s capacity to deliver CPHC. It also enabled the researcher to bring her own assumptions to the
research subject area and construct meaning about the organisation’s capacity to deliver CPHC.

Critical theory was an appropriate theoretical perspective to guide this research as it supported the change in FNQRDGP capacity to deliver CPHC which in turn contributes to the health and wellbeing of the communities it works with. Critical theory also encouraged the researcher to challenge her existing and more conservative assumptions about the potential role of CPHC in mobilising change processes at individual practice and organisational levels. The research highlighted for the researcher the importance of the alliance of values and principles with the nature of the change that one is trying to create. Critical theory was useful to interpret research results which were focused on a change process because it enabled the researcher to gain insight into the health services’ organisational systems and processes. Results then informed the actual changes required to support FNQRDGP’s organisational capacity to deliver CPHC.

Impact evaluation research was useful in this project as it provided an overarching framework to assess the short term changes of a CPHC ODS in the capacity of FNQRDGP to deliver CPHC. The researcher recognises that the scope of the evaluation was limited to short term change and that longer term outcome change would be important to evaluate in future similar research initiatives. Impact evaluation however did enable the researcher to address and answer the research question and sub-questions.

The theoretical frameworks, Framework for Building Capacity to Improve Health\(^{25}\) and the Health Promoting Health Services Reorientation Framework (HPHSRF),\(^{25}\) were useful in informing the development of the Capacity Indicator Framework (CIF). The design of the CIF and the impact assessment tool provided a structure for the results to be analysed and reported which directly aligned with the overall research question and three sub-questions.

While the design of the CIF and the impact assessment tool aligned well with the research question and sub-questions, results demonstrated that many of the
CIF indicators were interconnected and therefore difficult to position within discrete organisational components. During participant interviews indicators were frequently discussed outside of their component and related closer with other components. This meant that discussion about indicators was more dynamic and interconnected which is not reflected in the structural layout of the CIF and impact assessment tool. The literature acknowledges that organisation’s are complex, open systems rather than static and fixed,\textsuperscript{25, 88} therefore evaluation of change processes needs to reflect this. Consideration of systems and related theory in the design of instruments to assess changes in an organisation’s capacity to deliver CPHC would be important. In its current form the impact assessment tool used in this research does not explicitly reflect the dynamic interaction between the indicators of change from a complex systems perspective. The researcher believes this would assist in developing a deeper understanding about how indicators interact across different organisational components and what this means for developing and evaluating organisational capacity to deliver CPHC.

In addition the impact assessment tool would be strengthened through the inclusion of specific indicators and response categories for an organisational change component. This additional component would increase organisational learning about how to manage and sustain change. Johnson and Paton\textsuperscript{25} also emphasise the importance and need for more health services to focus on organisational change within reorientation strategies and to evaluate their application in practice. Including a specific focus on organisational change within the assessment tool would contribute to a greater body of literature around how health services can use organisational change strategies to reorient to CPHC. The more understanding that health services can gain about effective CPHC reorientation strategies, the more equitable health outcomes will be for individuals, communities and whole populations.\textsuperscript{26, 32, 144}

This chapter has discussed the research results in relation to the literature and the research design. The strengths and limitations of the research are presented below.
5.3 Strengths and limitations

5.3.1 Strengths

The strengths of this research include the following:

1. The research responds to a gap in knowledge about how to develop CPHC reorientation strategies that focus on organisational development and how to evaluate their impact.

2. The impact assessment instrument was developed from existing evidence-based capacity building and organisational change frameworks.

3. The structural design of the impact assessment instrument enabled research results to be analysed across four levels: 1) the overall impact of the CPHC ODS; 2) the impact of the three CPHC ODS components; 3) the impact of the eight CPHC ODS sub components; and 4) the impact of the 37 CPHC capacity indicators. Viewing results at multiple levels within and across the CIF helps to gain greater insight into why the change happened, and the enablers and barriers in the change process.

4. The research has responded to current Australian PHC policy directives that will require the reorientation of DGPs to PHCOs.

5. The engagement of staff that are directly impacted by the organisation’s capacity to deliver CPHC contributed to the relevance of the research results to the participants practice needs.

6. The research identification of a range of enablers and barriers that health services need to consider in the future development of CPHC ODSs.

5.3.2 Limitations

The limitations of this research include the following:

1. The researcher was learning through the research process how to apply organisational change theory to an organisational development strategy.
2. The results are limited to the participants’ and researcher’s interpretations.

3. The perspectives represented in the results are limited to those of the research participants; therefore the results are not general to a broader population.

4. The CIF and impact assessment tool may not have captured the full interaction of indicators across different organisational components.

5. The research timeframe limited the evaluation to shorter term impact evaluation.
6.0 Conclusion and recommendations

This chapter presents the conclusion for the research project and the recommendations from the research.

6.1 Conclusion

The aim of the research was to determine the impact of a comprehensive primary health care reorientation strategy with a focus on organisational development on FNQRDGP’s capacity to deliver CPHC. This responded to the following two research gaps identified in the literature: 1) the need for CPHC reorientation strategies to be based on organisational development; and 2) for the impact of CPHC reorientation strategies based on organisational development to be evaluated.

The overall research question asked: What is the impact of a CPHC ODS on the capacity of FNQRDGP to deliver CPHC? Research sub-questions asked: 1) What is the impact of a CPHC ODS on FNQRDGP’s workforce processes? 2) What is the impact of a CPHC ODS on FNQRDGP’s organisational processes? And 3) What is the impact of a CPHC ODS on FNQRDGP’s organisational culture?

This research was positioned within a constructivist epistemology, the theoretical perspective was critical theory and the research methodology was impact evaluation. A questionnaire and semi-structured individual interviews were used to collect and analyse quantitative and qualitative impact evaluation data from research participants, across three time points, in reference to organisational capacity components, subcomponents and indicators in order to answer the research questions.

There were thirteen research participants. From the pre to post impact evaluation time points, mean scores for 31 of the 37 indicators had statistically significant increases, with effect sizes for the increases ranging from moderate to nearly perfect. The majority of indicators had large or very large increases. Twenty nine (78%) of the indicators had significant increases from a lower
category at the pre time point to the High Performing category at the post time point. Twelve of the indicators (32%) shifted from Reactive to High Performing, two (5%) shifted from Reactive to Proactive and 17 (46%) shifted from Proactive to High Performing. These results indicate that the CPHC ODS increased FNQRDGP’s capacity to deliver CPHC.

Key enablers identified as being necessary to increase FNQRDGP’s capacity to deliver CPHC were: 1) dedicated leadership for CPHC teams with experience in and commitment to CPHC practice; 2) managers with health promotion background and acknowledgement of broad health determinants; 3) CPHC values and principles embedded in all aspects of the organisation’s functions; 4) health promotion theory and resources embedded within all areas and levels of the organisation; 5) whole of team professional development opportunities with a focus on health promotion and CPHC values and principles; 6) whole-of-team understanding about how to apply health promotion to enable CPHC practice; 7) dedicated whole-of-team time to reflect and evaluate organisation’s actions across CPHC continuum; 8) value for and support to conduct community engagement processes; 9) team structure reflects horizontal network compared to a hierarchical structure; 10) being listened to and valued by management by being trusted to use initiative and respected as a professional feeling empowered and able to make a difference.

Key barriers identified as limiting FNQRDGP’s capacity to deliver CPHC were: 1) not having a whole-of-organisation process to be accountable to communities’ identified priorities; 2) guidelines and deliverables attached to program funding; 3) competitive nature of funding between health services; 4) changes in the external environment that can impact negatively on morale; and 5) partnerships with key stakeholders that are not based on CPHC values and principles.

Discussion of the results in reference to the literature focused on the importance of a number of enablers and barriers within the three components of the CPHC ODS: 1) workforce development; 2) organisational processes; and 3) organisational culture. To develop workforce capacity to deliver CPHC it is
important that Managers reflect the change they want to see to ensure staff remain engaged in and feel supported through the change process. It is also important that Health Promotion Practitioners (HPPs) support other health professionals to understand how to translate CPHC philosophy into discipline-specific practice. A continuum of individual and whole-of-team professional development opportunities, both formal and informal was highlighted as a mechanism for supporting a range of learning styles which may in turn increase workforce capacity to deliver CPHC. It is also useful to develop human resource processes that link all stages of the employment cycle to CPHC and health promotion guidelines. Finally, developing policies and procedure based on health promotion strategy and action areas can be an effective way to support workforce development in CPHC.

To develop organisational processes to deliver CPHC it is important to dedicate an individual or a group to lead and manage the CPHC reorientation process as this is more likely to enhance effectiveness and sustainability of reorientation efforts. Positioning people with health promotion experience and skills across multiple levels of a health service may also be useful to increase overall capacity to deliver CPHC. Using health promotion processes, for example: needs assessment; planning; implementation; and evaluation can support continuous and ongoing quality improvement cycles for the whole organisation. Using health promotion action and strategy areas to develop policies and procedures provides a practical mechanism to enhance organisational processes that support CPHC delivery. Lastly, developing structured community engagement procedures to ensure quality engagement processes take place may support capacity to deliver CPHC.

To develop an organisational culture that supports CPHC it is important to dedicate whole-of-team time to reflect on team and individual CPHC performance and change processes that may enhance capacity to deliver CPHC. Using participatory and inclusive change processes is an effective way to involve as many staff members as possible in developing change which may lead to increased commitment and enthusiasm for change. Developing discipline-specific planned responses that address the broader range of
interrelated health determinants can support staff to feel empowered to make a difference. It is also important to align organisational practices and change processes with CPHC’s underlying holistic, ecological and salutogenic paradigm. This may enable the development of an organisational culture that drives and sustains CPHC practice. Changing the organisation’s value and mission statement to reflect CPHC values and principles may help to demonstrate genuine commitment to CPHC practice. Aligning change strategies with CPHC values and principles may support effectiveness, sustainability and commitment to the CPHC ODS.

In addition, the development of an organisational culture that supports CPHC delivery required the development of formal rewards and recognition programs which may help to demonstrate senior managements’ value for a CPHC teams’ work and achievements. Developing consistent levels of middle and senior management commitment to the CPHC reorientation process may be beneficial for staff commitment engagement with the change process. Celebrating ‘small wins’ may be an effective way to ensure staff members feel valued by management for the steps they are making towards achieving CPHC. Acknowledging each team member’s individual contribution to whole-of-team CPHC delivery may also be important in increasing job satisfaction and staff morale. Publicly demonstrating respect and value for interdisciplinary contribution to CPHC delivery may also further enhance the development of an integrated team approach. Finally, aligning management’s interactions with CPHC values and principles may support an authentic CPHC learning and change experience.

Overall research findings indicated that the CPHC ODS increased FNQRDGP’s capacity to deliver CPHC. Therefore implementing an ODS has the potential to positively impact on an organisation’s capacity to deliver CPHC. Health services involved in reorienting towards CPHC should consider using an ODS to achieve the desired changes. Attention to the barriers and enablers of capacity to deliver CPHC will assist the change process. Efforts to reorient services to CPHC should be evaluated in order to enhance their value to the organisation and to
the field of primary health care. Further research is required to determine the broader applicability and generalisability of the results to other similar settings.

6.2 Recommendations

As a result of this research the recommendations for research, practice and policy include the following:

6.2.1 Research

1. Conduct impact and outcome level evaluation on future strategies aimed at reorienting health services to deliver CPHC.

2. Further explore the influence of enablers and barriers on CPHC capacity in future organisational reorientation strategies.

3. Develop and evaluate reorientation frameworks that focus on the dynamic interaction between organisational capacity indicators and CPHC practice.

4. Ensure that organisational development theory and complex systems theory underpins future research focused on organisational capacity to deliver CPHC.

6.2.2 Practice

1. Managers interactions with staff need to reflect the change they want to see to in the organisation.

2. Establish organisational change processes based on the underlying values and principles of CPHC in order to drive and sustain a culture that supports CPHC practice.

3. Develop organisational infrastructure including health promotion expertise and resources that supports staff to deliver CPHC.
4. Ensure middle and senior management understand, share and are committed to a CPHC philosophy.

6.2.3 Policy

1. Advocate to funding bodies about the need for health promotion practitioner positions to be placed in all health related services, for example, in Divisions of General Practice to support the transition to PHC Organisations.

2. Advocate for more research to evaluate the impact of reorientation strategies that focus on organisational development.
7.0 References


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Impact evaluation of a CPHC ODS on a health service’s capacity to deliver comprehensive primary health care

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Appendix 1: Health Promoting Health Services - Organisational and Activities Assessment Tool

PART 1- ORGANISATIONAL ASSESSMENT

1. Reorientation goal

<table>
<thead>
<tr>
<th>Questions</th>
<th>Response to question(s)</th>
</tr>
</thead>
</table>
| (i) What is the goal for health promotion by leaders in your health service? (circle your response) | (a) To do health promotion activities and projects.  
(b) Delegate to someone to do health promotion on behalf of the service  
(c) Be a health promotion setting with an inward focus (develop an organizational commitment and support the staff to integrate health promotion into their practice).  
(d) Be a health promotion setting with a commitment to improving the health of the broader community served by the health service  
(e) Other (please specify) |
| (ii) What evidence do you have to support your assessment? (please describe) |  |
| (iii) If the response to (i) is not (d), is there a possibility for change in commitment? | □ YES □ NO □ N/A |
| (iv) If the response to (i) is not (d), what goal do you think is possible to achieve in the short term and why? |  |

2. Organisational health promotion program

A. TRANSFROMATIONAL FACTORS

<table>
<thead>
<tr>
<th>External environment</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) What are the factors external to the health service that are driving the health service to become more health promoting (for example, community and consumer views; funding requirements; government policy; regional policy; activities of other health services, etc)?</td>
<td></td>
</tr>
<tr>
<td>(ii) What are the factors external to the health service that are barriers to the health service becoming more health promoting (for example, community and consumer views; funding requirements; government policy; regional policy; practices of other health services, etc)?</td>
<td></td>
</tr>
<tr>
<td>(iii) Do community members and consumers provide input into the decision-making of the health service? If so, how, and what do they suggest?</td>
<td></td>
</tr>
<tr>
<td>(iv) Do other key stakeholders (other service providers) provide input into the decision-</td>
<td></td>
</tr>
</tbody>
</table>
making of the health service? If so, how, and what do they suggest?

**Leadership**

(i) Are the leaders (for example, Board members, CEO, Executive Directors) enthusiastic about being a health promoting health service? Who are they, and how do they view the health service’s role in health promotion? Are they able to influence the direction of the health service?

(ii) Do most of the leaders have a broad understanding of health and the determinants of health, and see a role for the health service in contributing to addressing these issues in your community? How do you know?

(iii) Do the leaders see reorienting the health service as a medium to long-term change process or are they looking for a 'quick fix' to a current problem?

(iv) Are the leaders committed to collaborating with other government and non-government agencies to plan and address health issues in the community? How do you know?

(v) Are the leaders committed to involving community members and health consumers in planning addressing health issues in the community, especially those who often do not have a voice in such matters?

(vi) Who is there to provide ‘technical’ leadership in the health service? For example, is there someone (or several people) who has in-depth knowledge about health promotion and has a vision for how health promotion can be integrated into the health service? Or do you need to get support from elsewhere?

**Mission and strategy**

(i) What is the mission of the health service? For example, is it service orientated or health orientated, and is it inward looking or outward focused?

(ii) What is the vision of the health service? Does it support a broader role in the health of the community?

(iii) What is the strategic direction of the health service? For example, does it contain strategies that will extend the role of the health service from reacting to health problems and demands on the service to those that embrace health promotion and improved health outcomes for the community? Do they embrace Primary Health Care principles?

(iv) Is there a health promotion strategy that includes integration into practice and population health priorities?

**Culture**

(i) Does the health service have a value statement? If so, is it congruent with Primary Health Care principles?

(ii) What would you say the ‘covert’ values of
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>(iii) Overall, would you say that the organizational culture of the health service is supportive of health promotion? How do you know?</td>
<td></td>
</tr>
<tr>
<td>(iv) Does the organisation willingly embrace well thought through change or is it really hard to change anything?</td>
<td></td>
</tr>
<tr>
<td>(v) Does the culture appear to embrace a more proactive approach to health promotion, or is the culture more oriented towards individual approaches to health promotion (for example, provision of health information and health education and addressing risk factors)?</td>
<td></td>
</tr>
<tr>
<td>(vi) Is there a history of health promotion in the health service, or is health promotion a new concept? If there is a history, what influence does that have on how health promotion is viewed in the health service? If it is a new concept, what are the drivers for it to occur?</td>
<td></td>
</tr>
<tr>
<td>(vii) Is there a competitive culture in the organisation where the organisational culture is to be leaders or ‘the best’?</td>
<td></td>
</tr>
<tr>
<td>(viii) Does the organisation celebrate success and achievement?</td>
<td></td>
</tr>
</tbody>
</table>

**B. TRANSACTIONAL FACTORS**

<table>
<thead>
<tr>
<th>Structure</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Is health promotion is shared responsibility or is it marginalised to a designated person or department?</td>
<td></td>
</tr>
<tr>
<td>(ii) Where does health promotion fit within the structure of the organisation? If there is a person designated to do health promotion or provide leadership to influence the health service to become more health promotion conscious, who are they accountable to?</td>
<td></td>
</tr>
<tr>
<td>(iii) Does the health service structure facilitate collaboration, both internally and externally? Is it hierarchical and inward focused, or is it more of a network structure with strong working collaboration with other services? Does it value a partnership approach?</td>
<td></td>
</tr>
<tr>
<td>(iv) Is there a committee structure to support health promotion innovation and provide accountability for actions? What type of committee is it? How often does it meet? What body does it report to in the health service?</td>
<td></td>
</tr>
</tbody>
</table>

**Management practices**

<p>| (i) Do managers work to translate the mission and strategies, and the leadership vision into action within the health service? |        |
| (ii) Do managers support and enable staff to integrate health promotion into their practice or do they block staff attempts? If so, how? |        |
| (iii) Describe how managers integrate a Primary Health Care philosophy into their management practice and the way the health care is delivered? For example, are they participatory in their decision making (including |        |</p>
<table>
<thead>
<tr>
<th><strong>System</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Is there a specific Health Promotion Policy for the health service? What approach to health promotion does it reflect?</td>
<td></td>
</tr>
<tr>
<td>(ii) Which other organizational policies have, or should have, aspects of health promotion integrated into them? How has or should health promotion be integrated into these other policies?</td>
<td></td>
</tr>
<tr>
<td>(iii) What information systems are in place, either within the health service or through other sources, to gather data about the health of the community? How easy is it to access that information? Is that data used for planning and monitoring?</td>
<td></td>
</tr>
<tr>
<td>(iv) Does the health service have a staff recognition program (for example, staff awards) where staff are acknowledged for their achievements in aspects of health promotion alongside clinical, education and research achievements?</td>
<td></td>
</tr>
<tr>
<td>(v) What human resources are allocated to provide health promotion leadership and support?</td>
<td></td>
</tr>
<tr>
<td>(vi) What financial resources are allocated to health promotion activities? That is, are they allocated at an organizational level, project level and/or department or unity level?</td>
<td></td>
</tr>
<tr>
<td><strong>Climate</strong></td>
<td></td>
</tr>
<tr>
<td>(i) What appears to be the attitude of staff who work in individual departments or units about health promotion? Is it mainly positive, or is it mainly negative?</td>
<td></td>
</tr>
<tr>
<td>(ii) Do departments or units feel supported by the organisation in their endeavours to integrate health promotion into their practices?</td>
<td></td>
</tr>
<tr>
<td><strong>Task requirements and individual skills/abilities and individual needs and values</strong></td>
<td></td>
</tr>
<tr>
<td>(i) Is health promotion written into job descriptions in a way that depicts the level of responsibility related to the job and shows that the job’s role in health promotion is understood by management?</td>
<td></td>
</tr>
<tr>
<td>(ii) Do staff feel as though they understand enough about health promotion theory to apply it to their practice in an effective way? If not, what additional support do they need?</td>
<td></td>
</tr>
<tr>
<td>(iii) What staff development and training is provided to staff about health promotion or relevant aspects of how is relates to what is expected of staff to do?</td>
<td></td>
</tr>
<tr>
<td>(iv) Do staff, who have a designated role in more formal health promotion programs, feel</td>
<td></td>
</tr>
</tbody>
</table>
that they are able to do their job well? If not, what additional support do they need?

**Motivation**

(i) Has the organisation sought the view of staff about their views about, and commitment to, health promotion?

(ii) Do staff generally feel motivated to support the health service embracing a broader role in health promotion to impact on the health of the community?

(iii) Do staff generally feel motivated to integrate health promotion into their practice, or do they think it should be someone else’s role?

(iv) Do staff feel that good practice in health promotion is valued and recognised in the health service?

**Individual, group and organisational performance**

(i) Do the key organisational performance indicators for the health service include indicators that incorporate Primary Health Care philosophy and health promotion action?

(ii) Is the agenda for reorienting the health service to become more health promoting part of the performance indicators? For example, do they include the shift to improving health of the broader community and consumer participation recognised as being a key performance indicator?

(iii) Do the individual departments and units have performance agreements, which include health promotion output indices that link the work of the department or unit to the organisational performance measures?

(iv) Is health promotion acknowledged as an important part of management and clinical performance through inclusion in staff performance appraisals? Are they performance indices related to the performance measures at department or unit level and organisational level where appropriate?

**PART 2**

3. Health promotion sub-program categories and health promotion approach

Briefly describe your setting (department or unit and where positioned in the health service, for example, community, hospital).

Can you please list under the following headings:

a) types of health promotion activities your department or unit is involved in?

b) what settings the initiative is based in? (for example, community, specific department, across the whole health service, etc)

c) which other departments, agencies and people your department or unit works with on these activities?
d) What strategies are used and what model of health promotion they relate to?

<table>
<thead>
<tr>
<th>Health promotion categories and initiatives</th>
<th>Setting for initiative</th>
<th>Other departments, agencies and people who you work with to implement these activities</th>
<th>List the health promotion strategies used (see health promotion approach on Framework) and identify what model of health promotion the strategies relate to (for example, medical, behavioural or socio-environmental)?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient and families</strong> (for example, patient and consumer-focused care; health education; safety promotion; social supports; and community linkages)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Staff</strong> (for example, primary prevention strategies; well-being activities; management policies and practices to support positive health initiatives)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Organisational</strong> (for example, legislated or mandated programs (infection control, occupational health and safety; non-smoking policy) and organisational development programs (migrant-friendly health services, baby-friendly health services and family-friendly policies))</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Physical environment</strong> (for example, building design; ‘green’ policies and practices; arts in health; advocacy for healthier environments)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Community</strong> (for example, information education and advocacy; empowerment; safety promotion; population health programs)</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
4. General questions for analysing Part 2 information

1 When analysing the above information, ask the following questions:
   
a) What is the main category (or categories) for health promotion activity?

   b) With whom does the department or unity mainly collaborate with (for example, internal or external services, community and consumers, etc)?

   c) What is the range of health promotion strategies and interventions used (for example, equitable and accessible health services; screening, individual risk assessment, immunisation; health information; health education, counselling and skill development; social marketing; organisational development; community action; economic and regulatory activities)? Does the department or unit utilise a range of strategies and interventions; or do they tend to only use one or a few?

   d) Is there a specific model of health promotion that dominates, or are various models used? (for example, medical, behavioural or socio-environmental)?

2 Based on analysis of the abovementioned information (using question 1), ask the following questions:

   a) What are the strengths of the department or unit’s work in health promotion?

   b) What are the weaknesses?

   c) What are the areas for improvement?

   d) What are the restraints and barriers to undertaking health promotion activities?

   e) What supports are needed to support improvements? Is this support needed from within the department or unit, or is it needed at the organisational level?

3 What are the health promotion priorities for the department or unit? How do these fit with the organisational priorities? What is the evidence base to support these priorities?

4 What needs to happen to support the department/unit’s staff to advance their commitment and involvement in health promotion to achieve the abovementioned priorities?

5 Any other comments?
## Appendix 2: Organisational prototype

**Your Organisational Prototype**

*Instructions*: Circle the number in each row that best describes your organisation’s current functioning (focus on a particular level: unit, department program or site).

<table>
<thead>
<tr>
<th></th>
<th>Reactive</th>
<th>Proactive</th>
<th>High performing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Focus</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Primarily clinical</td>
<td>Prevention and clinical care</td>
<td>Clinical, prevention and health promotion</td>
</tr>
<tr>
<td></td>
<td>1 2 3</td>
<td>4 5 6</td>
<td>7 8 9</td>
</tr>
<tr>
<td><strong>Level</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Individual</td>
<td>Individual, some outreach</td>
<td>Individual, community and population</td>
</tr>
<tr>
<td></td>
<td>1 2 3</td>
<td>4 5 6</td>
<td>7 8 9</td>
</tr>
<tr>
<td><strong>Time Frame</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Present “Fight fires”</td>
<td>Short/medium term</td>
<td>Short/long, investing in future</td>
</tr>
<tr>
<td></td>
<td>1 2 3</td>
<td>4 5 6</td>
<td>7 8 9</td>
</tr>
<tr>
<td><strong>Leadership</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Minimal or autocratic</td>
<td>Constructive</td>
<td>Visionary, inspiring</td>
</tr>
<tr>
<td></td>
<td>1 2 3</td>
<td>4 5 6</td>
<td>7 8 9</td>
</tr>
<tr>
<td><strong>Influence mode</strong></td>
<td></td>
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<tr>
<td></td>
<td>Controlling or laissez faire</td>
<td>Coaching</td>
<td>Empowering</td>
</tr>
<tr>
<td></td>
<td>1 2 3</td>
<td>4 5 6</td>
<td>7 8 9</td>
</tr>
<tr>
<td><strong>Quality orientation</strong></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Informal Self-proclaimed</td>
<td>Quality assurance</td>
<td>Continuous improvement</td>
</tr>
<tr>
<td></td>
<td>1 2 3</td>
<td>4 5 6</td>
<td>7 8 9</td>
</tr>
<tr>
<td><strong>Accountability mainly to</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Professionals</td>
<td>Patients/ Clients</td>
<td>Patients, professionals and public</td>
</tr>
<tr>
<td></td>
<td>1 2 3</td>
<td>4 5 6</td>
<td>7 8 9</td>
</tr>
<tr>
<td><strong>Management style</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Disorganized or rigid</td>
<td>Flexible</td>
<td>Synergistic participatory</td>
</tr>
<tr>
<td></td>
<td>1 2 3</td>
<td>4 5 6</td>
<td>7 8 9</td>
</tr>
<tr>
<td><strong>Communication</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>One-way sporadic</td>
<td>Two-way</td>
<td>Multi-directional, continual</td>
</tr>
<tr>
<td></td>
<td>1 2 3</td>
<td>4 5 6</td>
<td>7 8 9</td>
</tr>
<tr>
<td><strong>Professional development</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Low priority</td>
<td>Optional, opportunistic</td>
<td>High priority, ongoing</td>
</tr>
<tr>
<td></td>
<td>1 2 3</td>
<td>4 5 6</td>
<td>7 8 9</td>
</tr>
<tr>
<td><strong>Morale</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Complacency, discouraged</td>
<td>Supportive, encouraging</td>
<td>High, self-sustaining</td>
</tr>
<tr>
<td></td>
<td>1 2 3</td>
<td>4 5 6</td>
<td>7 8 9</td>
</tr>
</tbody>
</table>

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Appendix 3: Ethics confirmation

Barbara Palmer  
Manager, Office of Research  

November 25, 2008

Dr Jane Gregg  
Faculty of Science, Health and Education  

Ms Michelle Costello  
Far North Queensland Rural Division of General Practice  
2/220 Severin Street  
PARRAMATTA PARK QLD 4870

Dear Jane and Michelle

EXPEDITED ETHICS APPROVAL FOR AMENDED RESEARCH PROJECT – Impact evaluation of an organisational development strategy aimed at increasing the capacity of Far North Queensland Rural Division of General Practice to deliver comprehensive primary health care (5/08/160)

This letter is to confirm that on 25 November 2008, the Chairperson of the Human Research Ethics Committee of the University of the Sunshine Coast granted expedited ethics approval for amendments to the project, Impact evaluation of an organisational development strategy aimed at increasing the capacity of Far North Queensland Rural Division of General Practice to deliver comprehensive primary health care (5/08/160).

The amendments to the project relate to:

- The employment of an independent interviewer;
- The removal of identifying questions from the survey questionnaire;
- The use of more specific survey questions; and
- Reference to two time points (April and November) at the first data collection point.

The conditions for ethics approval for this project as outlined in our letter of 8 October 2008 continue to apply.

If you have any queries in relation to this matter or if you require further information please contact me by email at humanethics@usc.edu.au or by telephone on (07) 5459 4574.

Yours sincerely

Barbara Palmer  
Manager  
Office of Research
Appendix 4: Capacity Indicator Framework to Assess Organisational Capacity to Deliver Comprehensive Primary Health Care

### Overall view of organisation

<table>
<thead>
<tr>
<th></th>
<th>Reactive</th>
<th>Proactive</th>
<th>High performing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mission and Strategy</td>
<td>Primarily clinical, inward oriented</td>
<td>Prevention and clinical care, service oriented</td>
<td>Clinical prevention and health promotion, outward oriented</td>
</tr>
<tr>
<td>Strategic direction</td>
<td>React to health problems and demands</td>
<td>Respond to community need through clinical and health promotion services</td>
<td>Embrace comprehensive primary health care principles to improve health outcomes for communities</td>
</tr>
<tr>
<td>Level of care</td>
<td>Individual</td>
<td>Individual, some outreach</td>
<td>Individual, community and population</td>
</tr>
<tr>
<td>Focus of activity</td>
<td>Present - &quot;fight fires&quot;</td>
<td>Short to medium term</td>
<td>Short, medium and long term, investing in the future</td>
</tr>
<tr>
<td>Management style</td>
<td>Controlling or laissez faire</td>
<td>Coaching</td>
<td>Empowering, participatory</td>
</tr>
<tr>
<td>Type of quality improvement within programs</td>
<td>Informal, self-proclaimed</td>
<td>Management driven</td>
<td>Continuous improvement driven by community feedback</td>
</tr>
<tr>
<td>Accountability</td>
<td>Mainly to professionals</td>
<td>Mainly to patients or clients</td>
<td>Inclusive of patients, clients, professionals and public</td>
</tr>
<tr>
<td>Communication</td>
<td>One-way or sporadic</td>
<td>Two-way</td>
<td>Multi-directional, continual</td>
</tr>
<tr>
<td>Morale</td>
<td>Complacency, discouraged</td>
<td>Supportive, encouraging</td>
<td>High, self-sustaining</td>
</tr>
</tbody>
</table>

### Organisational Structures

<table>
<thead>
<tr>
<th></th>
<th>Reactive</th>
<th>Proactive</th>
<th>High performing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisational structures and systems that support health promotion</td>
<td>Marginalised, designated person to do health promotion</td>
<td>Designated person incorporates health promotion into aspects of team work</td>
<td>Range of structures to support health promotion activity at multiple levels</td>
</tr>
<tr>
<td>Organisation’s approach to collaboration</td>
<td>Internal</td>
<td>Internal and external</td>
<td>Partnership approach, committed to productive collaboration with other services</td>
</tr>
<tr>
<td>Organisational Structures</td>
<td>Hierarchical, inward focus</td>
<td>Network structure</td>
<td>Network organisation, outward focus</td>
</tr>
<tr>
<td>Management practices</td>
<td>Block staff attempts to practice health promotion</td>
<td>Managers support and enable staff to integrate health promotion into their practice</td>
<td>Managers integrate a comprehensive primary health care philosophy into their management practice and the way the health service is delivered</td>
</tr>
</tbody>
</table>
### Organisational Culture

<table>
<thead>
<tr>
<th></th>
<th>Reactive</th>
<th>Proactive</th>
<th>High performing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisation values</td>
<td>Values that support clinical practice</td>
<td>Supportive of comprehensive primary health care values</td>
<td>Value statement congruent with CPHC principles</td>
</tr>
<tr>
<td>Organisation’s response to change</td>
<td>Resistant, hard to change practices</td>
<td>Staff encouraged to voice ideas of change</td>
<td>Willingly embrace well-thought through change</td>
</tr>
<tr>
<td>Health promotion programs</td>
<td>Individual focus, health education, addressing risk factors</td>
<td>Group focus, connection between behaviours and lifestyle</td>
<td>Holistic approach, connection between spiritual, emotional, physical, environmental, social, economic and political factors</td>
</tr>
<tr>
<td>History of health promotion in organisation</td>
<td>New concept</td>
<td>Individuals practice health promotion</td>
<td>Well established, incorporated into job descriptions and performance appraisals</td>
</tr>
<tr>
<td>Attitudes within organisation towards health promotion</td>
<td>Negative, resistant</td>
<td>Positive, open</td>
<td>Inspiring, empowering</td>
</tr>
<tr>
<td>Organisation’s response to success and achievement</td>
<td>Self-proclaimed</td>
<td>Informal, management recognition</td>
<td>Team celebration</td>
</tr>
</tbody>
</table>

### Organisational Systems

<table>
<thead>
<tr>
<th></th>
<th>Reactive</th>
<th>Proactive</th>
<th>High performing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisational policies and processes</td>
<td>Limited reference to comprehensive primary health care delivery</td>
<td>General reference to comprehensive primary health care delivery</td>
<td>Specific and consistent reference to comprehensive primary health care delivery</td>
</tr>
<tr>
<td>Human resources</td>
<td>Limited health promotion support and leadership</td>
<td>Health promotion positions designated to specific projects</td>
<td>Human resources allocated to provide health promotion support and leadership</td>
</tr>
<tr>
<td>Health promotion program planning</td>
<td>Staff required to develop individual health promotion plans with limited support</td>
<td>Support outside of organisation is available to help staff with health promotion planning</td>
<td>Someone (or several people) within the organisation has in-depth knowledge about health promotion</td>
</tr>
<tr>
<td>Whole-of-team meetings inclusion of CPHC and health promotion</td>
<td>Limited, infrequent</td>
<td>Consistent, helpful to team</td>
<td>Frequent, team nominate relevant training sessions to better skills, knowledge and confidence</td>
</tr>
<tr>
<td>Professional development opportunities</td>
<td>Low priority</td>
<td>Optional, opportunistic</td>
<td>High priority, ongoing</td>
</tr>
<tr>
<td>Reward systems for achievements in CPHC work</td>
<td>External rewards (money, titles,)</td>
<td>Verbal recognition from management</td>
<td>Formal, performance appraisals, staff recognition programs</td>
</tr>
</tbody>
</table>
## Needs and Values

<table>
<thead>
<tr>
<th></th>
<th>Reactive</th>
<th>Proactive</th>
<th>High performing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual needs and values to conduct CPHC</strong></td>
<td>Needs not met, staff struggle to conduct full scope of primary health care</td>
<td>Feedback structures to enable staff needs to be met where possible</td>
<td>Staff needs to deliver CPHC are integrated into organisational policy and practice</td>
</tr>
<tr>
<td><strong>Motivation for CPHC work</strong></td>
<td>Management view health promotion as “someone else’s” role</td>
<td>Management promote health promotion as important to the health in the community</td>
<td>Health promotion is valued and recognised by management as an important part of all staff roles</td>
</tr>
</tbody>
</table>

## Organisational Leadership

<table>
<thead>
<tr>
<th></th>
<th>Reactive</th>
<th>Proactive</th>
<th>High performing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Leadership in CPHC</strong></td>
<td>Minimal or autocratic</td>
<td>Management of roles and task accomplishments, setting objectives, efficient resource use</td>
<td>Visionary, inspiring, commitment to CPHC philosophy, CPHC integrated into core business</td>
</tr>
<tr>
<td><strong>Program goals and outcomes</strong></td>
<td>Limited reflection on primary health care goals and outcomes</td>
<td>Periodical reflection of primary health care goals and outcomes</td>
<td>Ongoing reflection of CPHC goals and outcomes. Actively reorient work to reflect CPHC principles</td>
</tr>
<tr>
<td><strong>Understanding of health</strong></td>
<td>An absence of disease and illness, chronic disease focus, curative services</td>
<td>Acknowledge connections between social conditions and health outcomes</td>
<td>Acknowledge broad determinants of health and see a role for health service in contributing to addressing issues and creating healthy conditions in communities</td>
</tr>
<tr>
<td><strong>Priorities</strong></td>
<td>Leaders set priorities for health service</td>
<td>Leaders are responsive to local health issues</td>
<td>Leaders facilitate opportunities for community to determine health service priorities</td>
</tr>
<tr>
<td><strong>Planning by managers</strong></td>
<td>Plan and structure services/programs with limited input from stakeholders</td>
<td>Seek feedback from “easy to reach” stakeholders on pre-developed services/programs</td>
<td>Committed to participatory decision making in planning, implementation and evaluation stages of services/programs</td>
</tr>
</tbody>
</table>

## Task Requirements

<table>
<thead>
<tr>
<th></th>
<th>Reactive</th>
<th>Proactive</th>
<th>High performing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CPHC duties and accountabilities in job descriptions</strong></td>
<td>Static, non-reflective, same description for each discipline</td>
<td>Management develop job descriptions and propose changes to reflect disciplines</td>
<td>Reflective, evolving, staff propose changes to reflect disciplines</td>
</tr>
<tr>
<td><strong>Staff performance indicators</strong></td>
<td>Limited reference to primary health care philosophy</td>
<td>Staff performance indicators incorporate primary health care philosophy into health promotion</td>
<td>Agenda for reorienting health services to become more health promoting is part of staff performance indicators</td>
</tr>
<tr>
<td><strong>Direction and support for staff in CPHC</strong></td>
<td>Limited direction and support</td>
<td>Informal direction and support</td>
<td>Frequent planning, reflective team opportunities</td>
</tr>
<tr>
<td>External Environment</td>
<td>Reactive</td>
<td>Proactive</td>
<td>High performing</td>
</tr>
<tr>
<td>------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Community input</td>
<td>Limited or inappropriate consultation processes</td>
<td>Frequent evaluation of services and programs</td>
<td>Built into formal evaluation processes, policies and procedures</td>
</tr>
<tr>
<td>Key stakeholders</td>
<td>Limited or inappropriate consultation processes</td>
<td>Frequent evaluation of services and programs</td>
<td>Input built into formal evaluation processes and policies/procedures</td>
</tr>
</tbody>
</table>

Impact evaluation of a CPHC ODS on a health service’s capacity to deliver public health care
Appendix 5: CPHC organisational development strategy activities

This document is based on a combination of indicators from the *Framework for Building Capacity to Improve Health* (2001)\(^7\) and the *Health Promoting Health Services Reorientation Framework* (2006)\(^25\). The document was developed in the early stages of strategy development as a log for the PHC manager to monitor and track evidence of action against activities within the Comprehensive Primary Health Care Organisational Development Strategy (CPHC ODS).
## Component of CPHC-focused ODS: Organisational Processes

**Refers to processes that ensure the structures, systems, policies, procedures and practices of a service reflect the role, values and objectives and ensure the change is managed effectively**

<table>
<thead>
<tr>
<th>Element</th>
<th>Activity</th>
<th>Evidence of action</th>
</tr>
</thead>
</table>
| Polices and strategic plans | Identify and enhance opportunities to incorporate health promotion action into core business of PHC Cape York Team | - All members of PHC Cape York Team have action plans based on modern health promotion values, principles and processes  
- Reporting framework reflects full scope of CPHC delivery (downstream, midstream and upstream) |
| Organisational management structures | Establish health promotion positions within executive structures | - PHC Manager has qualifications and experience in health promotion |
| | Incorporate health promotion into recruitment and orientation procedures, performance agreements and job descriptions at all levels in the PHC Cape York Team | - Specific interview questions reflect health promotion and CPHC values and practice  
- Key health promotion documents included in orientation pack (i.e. Ottawa Charter for Health Promotion, Declaration of Alma Ata)  
- Discipline-specific job descriptions based on Ottawa Charter for Health Promotion five action areas |
| | Monitor work performance to ensure appropriate time is allocated to health promotion action | - Weekly reporting framework illustrates proportion of time spent on downstream, midstream and upstream health promotion action |
| Management support and commitment | Develop systems to support PHC Cape York Team commitment to health promotion | - Developed 'Blue-Stream' reporting structure to increase health promotion support for allied health staff, provide opportunity for regular reflective practice; and improve reporting of full scope of CPHC delivery to Department of Health and Ageing (DoHA)  
- Action plan template and reporting framework based on modern health promotion values, principles and processes  
- PHC Cape York Team feedback fortnightly to health promotion practitioners on progress and support with health promotion planning, implementation and evaluation  
- Support strategy in place to discuss values and principles of modern health promotion processes |
| | Develop accountabilities for health promotion within PHC Cape York Team | - Same as above |
| Information systems – monitoring and evaluation | Develop systems that accurately identify the amount and type of health promotion action undertaken by staff | - Weekly reporting frameworks reflect health promotion of a downstream, midstream and upstream nature |
| | Incorporate health promotion into staff appraisal processes | - Process, impact and outcome evaluation indicators and tools listed in discipline-specific action plans |
| | Develop specific information gathering tools to be used by health promotion practitioners to monitor health promotion work conducted by allied health professionals | - Feedback Friday: reflective practice questions used by health promotion practitioners  
- Blue-stream meetings to feedback health promotion progress and extra resources/support needed to progress CPHC delivery |
| | Use available best practice tools for health promotion | - Red Lotus Model for Health Promotion and Ottawa Charter for Health Promotion used for planning, implementation and evaluation of all PHC Cape York Team work |
| Informal organisational culture | Seek to encourage attitudes which support health promotion action | - Support strategy in place to support the development of PHC Cape York staff members’ skills, knowledge, understanding and confidence in modern health promotion processes  
- PHC Manager supports all health promotion programs based on modern health promotion processes, values and principles |
## Component of CPHC-focused ODS: Workforce Development

Refers to processes that ensure the people working within the system have the abilities and commitment to contribute to organisational and community goals.

<table>
<thead>
<tr>
<th>Element</th>
<th>Activity</th>
<th>Evidence of action</th>
</tr>
</thead>
</table>
| On the job learning opportunities | Provide a range of opportunities for members of PHC Cape York Team to learn about health promotion | • Whole-of-team workshop: what is primary health care and health promotion (April 2008)  
• Whole-of-team workshop: learning about the Ottawa Charter of Health Promotion (May 2008)  
• Whole-of-team planning: establish action plans based on CPHC values and Ottawa Charter action areas (May 2008)  
• Show case team examples of health promotion and CPHC delivery (August 2008)  
• Whole-of-team meeting: review and reflect on Cape outcomes from 2006-2008 (December 2008)  
• Whole-of-team workshop and planning with Red Lotus Model of Health Promotion (January 2009)  
• Fortnightly support strategy for Red Lotus Model of Health Promotion: conducted by Jane Gregg, Lecturer in Health Promotion at University of Sunshine Coast (January-July 2009)  
• Email group established to encourage communication about learnings from Red Lotus Model of Health Promotion support strategy |
| Professional development opportunities | Disseminate information about, and support external opportunities relevant to health promotion | • PHC Manager and health promotion practitioners members of Australian Health Promotion Association (AHPA) – all relevant information distributed to PHC Cape York Team  
• Staff members x 3 supported to undertaken specific study in health promotion through Brisbane, Sydney and Melbourne universities |
| Professional support and supervision systems | Establish formal supervision or support arrangements for health promotion work | • ‘Feedback Friday’: feedback progress and provide support for progress of health promotion plans facilitated by health promotion practitioners |
| Provide access to specialist advice and support through networks | | • Fortnightly support strategy for Red Lotus Model of Health Promotion: conducted by Jane Gregg, Lecturer in Health Promotion at University of Sunshine Coast (January-July 2009) |
| Performance management systems | Incorporate health promotion work into regular performance appraisal or performance management systems | • Amount and type of health promotion included in staff appraisal processes |
### Impact evaluation of a CPHC ODS on a health service’s capacity to deliver public health care

#### Component of CPHC-focused ODS: Resource allocation

| Resources include things needed to support a program including: people, physical space, administrative support, planning tools and financial support |
|---|---|---|
| **Element** | **Activity** | **Evidence of action** |
| Financial resources | Lobbying for an appropriate proportion of PHC Cape York program’s funding to be allocated to health promotion action | PHC Cape York programs initially well funded for health promotion action |
|  | Actively disseminate information about funding opportunities to other organisations so they might become interested in health promotion | PHC Cape York Team provided several letters of support for funding submissions related to health promotion |
|  | Support other organisations with an interest in health promotion who have limited budgets | PHC Cape York Team provide financial, human and physical resources to support Queensland Health and community organisations/groups to deliver health promotion initiatives |
|  | Ensure financial resources allocated to health promotion action are used in sustainable and meaningful ways | Guidelines developed on how health promotion funding can be spent |
|  |  | Request to use funding for health promotion form developed: all health promotion funding requests will only be approved if linked back to broader action plan goals |
| Human resources development | Establishment of ‘core’ health promotion positions to support program | 2 x Health Promotion Practitioner roles re-structured from cluster based positions to discipline-specific programs |
|  |  | Health Promotion Practitioner A provides health promotion planning, implementation and evaluation support to: Dietitian; Physiotherapist and Social and Emotional Well-being Team (Hope Vale and Wujal) |
|  |  | Health Promotion Practitioner B provides health promotion planning, implementation and evaluation support to: Diabetes Educator; Medical Officer; Podiatrist; and Social and Emotional Well-Being Team (Mossman) |
|  | Lobbying for a fixed percentage of PHC Cape York Team’s time to be allocated to midstream and upstream health promotion action | Developed reporting framework to assess proportion of health promotion time being spent down, mid and upstream |
|  |  | Developed discipline-specific action plans to ensure PHC Cape York Team developed strategies that reflect the five action areas of the Ottawa Charter for Health Promotion |
|  | Developing opportunities for other organisations (outside of health system) to apply a health promoting approach | Discipline-specific action plans detail secondary co-activists (people who can help achieve the change) both in and outside of health system (i.e. local stores, schools, community organisations, local council, department of transport) |
|  | Build a base of advocates for health promotion within health and other sectors, and in particular, at senior management levels | PHC Cape York Team advocate for health promotion action through implementation of action plans based on the Ottawa Charter for Health Promotion and modern health promotion values and principles |
|  |  | PHC Manager advocates for health promotion action at regional committees and meetings with senior management present |
| Information | Ensuring availability and use of information to support health promotion action (i.e. literature reviews, health status, national goals, best practice tools) | All PHC Cape York Team have access to information that supports health promotion action |
|  |  | All discipline-specific plans were based on literature reviews, national goals and best practice tools |
| Specialist advice | Ensuring access to health promotion expertise when required | 2 x Health Promotion Practitioners to support team |
|  |  | PHC Manager has qualifications and experience in health promotion |
|  |  | Lecturer in Health Promotion from University of Sunshine Coast available for support |
| Decision-making tools and models | Provide no-cost or low cost to health promotion skills and development courses for potential program partners in the community and other sectors | Health Promotion Practitioners provide up skilling workshops in health promotion theory and action to community organisations (free of charge) |
| Administrative and physical resources | Utilise best practice models in health promotion/or standards for health promotion | All plans based on Ottawa Charter for Health Promotion and Red Lotus Model for Health Promotion |
|  | Ensuring the availability of clerical or administrative support, equipment, office and meeting space | Adequate administrative support, equipment, office and meeting space available to support health promotion action |
Appendix 6: Recruitment email message

Subject: Research Project for IPHCI

Hello,

Recently the IPHCI team has been involved in discussion about the benefits of working from a comprehensive primary health care approach (CPHC). FNQRDGP is committed to achieving health outcomes for communities and would like to reorient the organisation to ensure delivery of CPHC through its programs.

FNQRDGP is currently working on an organisational development strategy to enhance its capacity to deliver CPHC in communities. As part of this process we are conducting a research project to evaluate the impact of the strategy on the organisation’s capacity to deliver CPHC.

The IPHCI team has been identified as the team to start this process. We would therefore like to invite people from, or closely related to, the IPHCI program to participate in this research. This would involve completing a questionnaire and participating in individual face-to-face interviews before and after the implementation of a six-month organisational development strategy. The questionnaire will ask you to rate a range of organisational processes that impact on FNQRDGP’s capacity to deliver CPHC. Interviews will be conducted by Michelle Costello to collect more in-depth information on organisational processes that impact on FNQRDGP’s capacity to deliver CPHC.

All questions are based on rating FNQRDGP’s capacity as an organisation to deliver CPHC. No information will be asked or recorded about individual CPHC delivery or performance.

Involvement in this project will allow you to contribute your ideas to how FNQRDGP can better deliver CPHC. This information will be used to help contribute to effective and sustainable health services in communities.

For more information on the research see the information sheet attached to this email.

Please ask Michelle any questions you may have.

Michelle Costello
Primary Health Care Manager – Cape York
Masters of Science Student and Principal Researcher
School of Health and Sport Sciences
Faculty of Health, Science and Education

Supervisors

Jane Gregg and Lily O’Hara
School of Health and Sport Sciences
Faculty of Science, Health and Education
jgregg@usc.edu.au
Appendix 7: Research project information sheet

RESEARCH PROJECT INFORMATION SHEET

Project Title: Impact evaluation of an organisational development strategy aimed at increasing the capacity of Far North Queensland Rural Division of General Practice (FNQRDGP) to deliver comprehensive primary health care (CPHC).

Ethics approval: This research has been approved by the Human Research Ethics Committee of the University of the Sunshine Coast (approval number: S/08/160).

Description and aim of the research project: FNQRDGP is currently working on an organisational development strategy to enhance its capacity to deliver CPHC in communities. As part of this process FNQRDGP is conducting a research project to evaluate the impact of the strategy.

Research question: What is the impact of an organisational development strategy aimed at increasing the capacity of FNQRDGP to deliver CPHC?

When: This research project will be implemented at FNQRDGP during 2008 and 2009.

Who: Research participants will be recruited from the Improved Primary Health Care Initiative (IPHCI).

The research will be conducted through the University of the Sunshine Coast. Masters of Science student and Primary Health Care Manager for Cape York, Ms Michelle Costello, and Faculty of Science Health and Education, Public Health and Health Promotion researchers Ms Lily O’Hara and Ms Jane Gregg will oversee the research project.

Methods
IPHCI and closely related staff will be invited via email to participate in the research process. People willing to be involved in the project will participate in two data collection methods before and after implementation of the organisational development strategy:
1. Questionnaire to rate a range of organisational processes that impact on FNQRDGP’s capacity to deliver CPHC
2. Individual face-to-face interviews with principal researcher, Michelle Costello, to collect more in-depth information on organisational processes that impact on FNQRDGP’s capacity to deliver CPHC

This project is about improving the organisation’s capacity to deliver CPHC and therefore all results will de-identified and untraceable at the reporting level.

When will data be collected?
Data collection will be conducted during work hours when suited to IPHCI staff.
**How can I be involved?**

If interested in the research project please sign the consent form and return to Michelle Costello. Please contact Michelle if you require more information about involvement.

**Who will benefit from this research?**

IPHCI staff and FNQRDGP will receive a broad range of benefits from participating in the research project. Results from this research will be used to guide decisions around organisational processes to enhance FNQRDGP’s capacity to deliver CPHC. The increase in sustainable health outcomes from using a CPHC approach to deliver health services are now well documented (World Health Organisation). All participants will experience a sense of ownership and contribution to the future of how FNQRDGP can improve service delivery to communities and in the long term, it is hoped that the research project will contribute to improved health and wellbeing of communities serviced by FNQRDGP.

The research will also benefit other health professionals working in primary health care settings. The results of the project will provide insight into what health professionals need to do to reorient organisations to CPHC and how to do it. It will also benefit the principal researcher, Michelle Costello, who is undertaking the study as part of a Masters of Science degree at the University of the Sunshine Coast.

**Is participation voluntary?**

All IPHCI and closely related staff are invited to participate in this research project. Participation in the research project is voluntary and requires individual consent before you can participate. You do not have to give any reason to anyone if you decide not to take part. If you do decide to participate in this research project but later change your mind, you may stop your participation at any time without the need to provide an explanation. If this happens, any data collected to that point will remain in the analysis because it will not be possible to identify data on an individual basis once entered into the database.

Before you can participate in this research you will need to give your consent by signing the appropriate form called Consent to Participate in Research. This form is attached to this Research Project Information Sheet. Informed consent means that you give your consent to participate in the research project because you have been fully informed of what would be required of you. The information provided above is supplied to help you to decide whether or not you do consent to participate in this research project.

**What about my privacy?**

This research project will not be possible without the willingness of IPHCI staff to participate. All aspects of this research project will conform to the National Health and Medical Research Committee Guidelines for research involving humans, in particular research involving workplaces. As researchers, we will respect the privacy and the well-being of all staff who participate in this research.

Participants’ names will be collected for the survey so that follow-up interviews can be conducted with staff based on survey results. This two-staged data collection process will provide staff with the opportunity to: first consider organisational processes through a survey instrument and; second provide more in-depth responses about perceptions of FNQRDGP's capacity to deliver CPHC through a semi-structured interview. Conducting a mixed method study will provide a more in-depth understanding of how the ODS impacts on FNQRDGP's capacity to deliver CPHC.

This project is about improving the organisation's capacity to deliver CPHC and therefore all results will be identified and untraceable at the reporting level. It is likely that the de-identified data obtained from the study will be used to prepare a publication for submission to an
appropriate academic journal. The principal researcher will provide the results of the study in written form to FNQRDGP and also at a seminar in 2008 at the University of the Sunshine Coast as part of her Masters of Science Dissertation. Participants will be notified of the exact date and you and other interested parties are welcome to attend.

**Who can I contact for further information?**
If you have any complaints about the way this research project is being conducted you can either raise them with the Chief Investigator or, if you prefer an independent person, contact the Chairperson of the Human Research Ethics Committee at the University of the Sunshine Coast: (c/- The Academic Administration Officer, Teaching and Research Services, University of the Sunshine Coast, Maroochydore DC 4558; telephone (07) 5459 4574; facsimile (07) 5459 4727; email humanethics@usc.edu.au.

**Who are the researchers involved in the project?**

**Student and Principal Researcher**

Name: Ms Michelle Costello – Bachelor of Science: Public Health (Distinguished Academic Record); Bachelor of Business: Communication (Public Relations)

Position: Primary Health Care Manager – Cape York
Far North QLD Rural Division of General Practice
Masters of Science Student, Faculty of Science, Health and Education, University of the Sunshine Coast

Phone: 0417 001 935

Email: mcostello@fnqrdgp

Expertise: Michelle Costello has completed an undergraduate science degree in Public Health. During this time she was engaged to develop key components of community based projects about: healthy eating; healthy body image; physical activity; values education; adolescent depression and anxiety and health promoting schools work. Through involvement in these projects Michelle gained and in-depth understanding of the needs assessment, planning, implementation and evaluation stages of modern health promotion processes. She gained knowledge in research processes and tools. Michelle has worked as a tutor in public health and health promotion at the University of Sunshine Coast. She has worked in rural and remote Indigenous communities as a health promotion officer focusing on building capacity of communities, organisations and health workers to address community need. She has conducted workshops and presented her work at national conferences. She has also completed a business degree in Communication (Public relations). She was recently appointed as Primary Health Care Manager – Cape York for FNQRDGP.

**Supervisors**

Name: Ms Lily O’Hara

Position: Lecturer in Public Health, Faculty of Science, Health and Education, University of the Sunshine Coast

Phone: (07) 5430 2824

Email: lohara@usc.edu.au
Expertise: Lily O’Hara has a professional background as both a health promotion practitioner and academic. Her work has focused on: building the capacity of communities, organisations and health workers to address the determinants of health; and patterns of health related behaviours, beliefs and attitudes. Work on building capacity has included the assessment and development of infrastructure, systems and practice knowledge and skills. Work on patterns of health-related behaviours, beliefs and attitudes includes work on body image, eating behaviours, physical activity, social activity, food safety and the environmental conditions that impact on these. She has presented many workshops, seminars and lectures for health and education professionals, community organisations and schools on contemporary health promotion issues and best-practice. Lily has presented her work at national and international conferences and published in peer-reviewed journals.

Name: Ms Jane Gregg

Position: Lecturer in Health Promotion, Faculty of Science, Health and Education, University of the Sunshine Coast

Phone: (07) 5459 4639

Email: jgregg@usc.edu.au

Expertise: Jane Gregg is a qualified teacher, health promotion practitioner and academic. Her work has focused on community-based health promotion projects across a broad range of issues, evaluation of social and environmental programs, and participatory theories of practice in education and health promotion fields. She has extensive experience in the management and operation of large multi-disciplinary evaluation research projects gained through her work as a private consultant, and managed projects up the value of $200,000 per annum. Jane has presented many workshops, seminars and lectures for a range of health and health related sectors in health promotion best practice and participatory evaluation research. Jane has a particular interest in school-based health promotion research and the facilitation of collegial learning processes.

Michelle Costello, Jane Gregg and Lily O’Hara and the University of the Sunshine Coast, appreciate your participation in the research project. The researchers gratefully acknowledge the endorsement and support provided for this project by Far North QLD Rural Division of General Practice.
Appendix 8: Consent to participate in research

CONSENT TO PARTICIPATE IN RESEARCH

Project Title
Impact evaluation of an organisational development strategy aimed at increasing the capacity of Far North Queensland Rural Division of General Practice (FNQRDGP) to deliver comprehensive primary health care (CPHC).

Brief description of research project
FNQRDGP is currently working on an organisational development strategy to enhance its capacity to deliver CPHC in communities. As part of this process FNQRDGP is conducting a research project to evaluate the impact of the strategy on the organisation's capacity to deliver CPHC. This research project will be implemented during 2008 and 2009. Research participants will be recruited from the Improved Primary Health Care Initiative (IPCHI).

People willing to be involved in the project will participate in a questionnaire and a face-to-face interview before and after implementation of a six-month organisational development strategy. The questionnaire will ask IPCHI staff to rate a range of organisational processes that impact on FNQRDGP’s capacity to deliver CPHC. Participants will have seven working days to complete the questionnaire prior to individual interviews. Individual face-to-face Interviews will be conducted by Michelle Costello to collect more in-depth information on organisational processes that impact on FNQRDGP's capacity to deliver CPHC. Questionnaires and interviews will be conducted during work hours.

This project is about improving FNQRDGP's capacity to deliver CPHC and therefore no questions will be related to individual work performance and/or CPHC delivery. All results will be reported at a group level. Individual results will be identified and untraceable at the reporting level.

Freedom of Consent
I have read and understood the Research Project Information Sheet, which outlines the research aims, methods, and privacy aspects of this research project. I understand that:

- I do not have to participate in this research study if I do not want to.
- I can withdraw from the study at any time and do not have to give any reasons for my withdrawal.
- I will not be penalised or treated less favourably or lose any benefit if I do withdraw from the study.
- Feedback about the results of the study will be made available in the form of a lay summary of the overall outcomes of the research and will not identify any individual participants in the study.
- Any personal information provided by or obtained about me will be kept confidential, and no identifiable data will be used in any publication or presentations resulting from this research project.

I understand the contents of the Research Project Information Sheet for the research project “An evaluation of the impact of an organisational development strategy aimed at increasing the capacity of Far North Queensland Rural Division of General Practice to deliver comprehensive primary health care”. I agree to participate in this research project and give my consent freely. I understand that the project will be carried out as described on the Research Project Information Sheet, a copy of which I have kept. I realise that whether or not I participate in this research is my decision, and will not affect my work performance. I also realise that I can withdraw from the study at any time and that I do not have to give any reasons for withdrawing. Any questions I had about this research project and my participation in it have been answered to my satisfaction.

______________________  ___/___/___
Participant in research        Date
______________________  ___/___/___          ___/___/___
Principal Researcher        Date                  Independent witness      Date
Thank you for agreeing to participate in this assessment process. Results from this questionnaire* will contribute to evaluating the impact of an organisational development strategy aimed at increasing FNQRDG’s capacity to deliver comprehensive primary health care. The research findings will be used to enhance FNQRDG’s capacity to deliver comprehensive primary health care and contribute to improved health and well being in the communities that we work with.

Please complete this questionnaire in your interview with Jane Gregg.

* Questionnaire adapted from Organisational Prototype by Harvey Skinner and Richard Botelho, 2001
Organisational Capacity to Deliver Comprehensive Primary Health Care (CPHC)

Please tick the box which best describes your role in the organisation

- [ ] Health Professional
- [ ] Administration
- [ ] Management

**Instructions:** Circle one number in each row that best describes your perception of Far North Queensland’s Rural Division of General Practice’s primary health care practice in the programs they deliver.

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<thead>
<tr>
<th>Overall view of organisation</th>
<th>Reactive</th>
<th>Proactive</th>
<th>High performing</th>
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<tr>
<td><strong>Mission and Strategy</strong></td>
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<tr>
<td>Overall view of organisation</td>
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<td>2</td>
<td>3</td>
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<tr>
<td>Mission and Strategy</td>
<td></td>
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<tr>
<td>Mission and Strategy</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Mission and Strategy</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Mission and Strategy</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td><strong>Strategic direction</strong></td>
<td></td>
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<tr>
<td>Strategic direction</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>Strategic direction</td>
<td>1</td>
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<td>3</td>
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<td>Strategic direction</td>
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<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Strategic direction</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td><strong>Level of care</strong></td>
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<tr>
<td>Level of care</td>
<td>1</td>
<td>2</td>
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<td>Level of care</td>
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<td>Level of care</td>
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<td>6</td>
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<tr>
<td>Level of care</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td><strong>Focus of activity</strong></td>
<td></td>
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<tr>
<td>Focus of activity</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Focus of activity</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Focus of activity</td>
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<td>6</td>
</tr>
<tr>
<td>Focus of activity</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Management style</td>
<td>Controlling or laissez faire</td>
<td>Coaching</td>
<td>Empowering, participatory</td>
</tr>
<tr>
<td>------------------</td>
<td>-----------------------------</td>
<td>----------</td>
<td>---------------------------</td>
</tr>
<tr>
<td></td>
<td>1 2 3</td>
<td>4 5 6</td>
<td>7 8 9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of quality improvement within programs</th>
<th>Informal, self-proclaimed</th>
<th>Management driven</th>
<th>Continuous improvement driven by community feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 2 3</td>
<td>4 5 6</td>
<td>7 8 9</td>
</tr>
</tbody>
</table>

Overall view of the organisation cont...

<table>
<thead>
<tr>
<th>Reactive</th>
<th>Proactive</th>
<th>High performing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountability</td>
<td>Mainly to professionals</td>
<td>Mainly to patients or clients</td>
</tr>
<tr>
<td></td>
<td>1 2 3</td>
<td>4 5 6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Communication</th>
<th>One-way or sporadic</th>
<th>Two-way</th>
<th>Multi-directional, continual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 2 3</td>
<td>4 5 6</td>
<td>7 8 9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Morale</th>
<th>Complacency, discouraged</th>
<th>Supportive, encouraging</th>
<th>High, self-sustaining</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 2 3</td>
<td>4 5 6</td>
<td>7 8 9</td>
</tr>
</tbody>
</table>

Organisational Structures

| Organisational structures and systems that support health promotion | Marginalised, designated person to do health promotion | Designated person incorporates health promotion into aspects of team work | Range of structures to support health promotion activity at multiple levels |
|-------------------------------------------------------------------|-----------------------------------------------------|-----------------------------------------------------------------------|
|                                                                  | 1 2 3                                               | 4 5 6                                                                | 7 8 9                                                                   |

<table>
<thead>
<tr>
<th>Organisation’s approach to collaboration</th>
<th>Internal</th>
<th>Internal and external</th>
<th>Partnership approach, committed to productive collaboration with other services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 2 3</td>
<td>4 5 6</td>
<td>7 8 9</td>
</tr>
</tbody>
</table>
### Organisational Structures

<table>
<thead>
<tr>
<th></th>
<th>Hierarchical, inward focus</th>
<th>Network structure</th>
<th>Network organisation, outward focus</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1  2  3</td>
<td>4  5  6</td>
<td>7  8  9</td>
</tr>
</tbody>
</table>

### Management practices

<table>
<thead>
<tr>
<th></th>
<th>Block staff attempts to practice health promotion</th>
<th>Managers support and enable staff to integrate health promotion into their practice</th>
<th>Managers integrate a comprehensive primary health care philosophy into their management practice and the way the health service is delivered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1  2  3</td>
<td>4  5  6</td>
<td>7  8  9</td>
</tr>
</tbody>
</table>

### Organisational Culture

### Organisation values

<table>
<thead>
<tr>
<th></th>
<th>Values that support clinical practice</th>
<th>Supportive of comprehensive primary health care values</th>
<th>Value statement congruent with CPHC principles</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1  2  3</td>
<td>4  5  6</td>
<td>7  8  9</td>
</tr>
</tbody>
</table>

### Organisation’s response to change

<table>
<thead>
<tr>
<th></th>
<th>Resistant, hard to change practices</th>
<th>Staff encouraged to voice ideas of change</th>
<th>Willingly embrace well-thought through change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1  2  3</td>
<td>4  5  6</td>
<td>7  8  9</td>
</tr>
</tbody>
</table>

### Organisational Culture cont...

#### Health promotion programs

<table>
<thead>
<tr>
<th></th>
<th>Reactive</th>
<th>Proactive</th>
<th>High performing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health promotion programs</td>
<td>Individual focus, health education, addressing risk factors</td>
<td>Group focus, connection between behaviours and lifestyle</td>
<td>Holistic approach, connection between spiritual, emotional, physical, environmental, social, economic and political factors</td>
</tr>
<tr>
<td></td>
<td>1  2  3</td>
<td>4  5  6</td>
<td>7  8  9</td>
</tr>
</tbody>
</table>

#### History of health promotion in organisation

|                                | New concept | Individuals practice health promotion | Well established, incorporated into job descriptions and performance appraisals |
| History of health promotion in organisation | 1  2  3 | 4  5  6 | 7  8  9 |

#### Attitudes within organisation towards health promotion

|                                | Negative, resistant | Positive, open | Inspiring, empowering |
|                                | 1  2  3             | 4  5  6        | 7  8  9              |

#### Organisation’s response to success and achievement

|                                | Self-proclaimed | Informal, management recognition | Team celebration |
|                                | 1  2  3         | 4  5  6                         | 7  8  9          |
### Organisational Systems

<table>
<thead>
<tr>
<th>Organisational policies and processes</th>
<th>Limited reference to comprehensive primary health care delivery</th>
<th>General reference to comprehensive primary health care delivery</th>
<th>Specific and consistent reference to comprehensive primary health care delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human resources</td>
<td>Limited health promotion support and leadership</td>
<td>Health promotion positions designated to specific projects</td>
<td>Human resources allocated to provide health promotion support and leadership</td>
</tr>
<tr>
<td>Health promotion program planning</td>
<td>Staff required to develop individual health promotion plans with limited support</td>
<td>Support outside of organisation is available to help staff with health promotion planning</td>
<td>Someone (or several people) within the organisation has in-depth knowledge about health promotion</td>
</tr>
<tr>
<td>Whole-of-team meetings inclusion of CPHC and health promotion</td>
<td>Limited, infrequent</td>
<td>Consistent, helpful to team</td>
<td>Frequent, team nominate relevant training sessions to better skills, knowledge and confidence</td>
</tr>
<tr>
<td>Professional development opportunities</td>
<td>Low priority</td>
<td>Optional, opportunistic</td>
<td>High priority, ongoing</td>
</tr>
</tbody>
</table>

### Organisational systems cont...

<table>
<thead>
<tr>
<th>Reward systems for achievements in CPHC work</th>
<th>Reactive</th>
<th>Proactive</th>
<th>High performing</th>
</tr>
</thead>
<tbody>
<tr>
<td>External rewards (money, titles,)</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Verbal recognition from management</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Formal, performance appraisals, staff recognition programs</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>

### Needs and Values

<table>
<thead>
<tr>
<th>Individual needs and values to conduct CPHC</th>
<th>Needs not met, staff struggle to conduct full scope of primary health care</th>
<th>Feedback structures to enable staff needs to be met where possible</th>
<th>Staff needs to deliver CPHC are integrated into organisational policy and practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motivation for CPHC work</td>
<td>Management view health promotion as &quot;someone else’s&quot; role</td>
<td>Management promote health promotion as important to the health in the community</td>
<td>Health promotion is valued and recognised by management as an important part of all staff roles</td>
</tr>
</tbody>
</table>

Impact evaluation of a CPHC ODS on a health service’s capacity to deliver public health care
### Organisational Leadership

<table>
<thead>
<tr>
<th>Leadership in CPHC</th>
<th>Minimal or autocratic</th>
<th>Management of roles and task accomplishments, setting objectives, efficient resource use</th>
<th>Visionary, inspiring, commitment to CPHC philosophy, CPHC integrated into core business</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
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<td>9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Program goals and outcomes</th>
<th>Limited reflection on primary health care goals and outcomes</th>
<th>Periodical reflection of primary health care goals and outcomes</th>
<th>Ongoing reflection of CPHC goals and outcomes. Actively reorient work to reflect CPHC principles</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
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<td>3</td>
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<tr>
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<td>4</td>
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<td>7</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Understanding of health</th>
<th>An absence of disease and illness, chronic disease focus, curative services</th>
<th>Acknowledge connections between social conditions and health outcomes</th>
<th>Acknowledge broad determinants of health and see a role for health service in contributing to addressing issues and creating healthy conditions in communities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
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<tr>
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<td>7</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Priorities</th>
<th>Leaders set priorities for health service</th>
<th>Leaders are responsive to local health issues</th>
<th>Leaders facilitate opportunities for community to determine health service priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
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<td>3</td>
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<tr>
<td></td>
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<td>6</td>
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<tr>
<td></td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Planning by managers</th>
<th>Plan and structure services/programs with limited input from stakeholders</th>
<th>Seek feedback from ‘easy to reach’ stakeholders on pre-developed services/programs</th>
<th>Committed to participatory decision making in planning, implementation and evaluation stages of services/programs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
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<td></td>
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<td></td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>

### Task Requirements

<table>
<thead>
<tr>
<th>Reactive</th>
<th>Proactive</th>
<th>High performing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CPHC duties and accountabilities in job descriptions</strong></td>
<td>Static, non-reflective, same description for each discipline</td>
<td>Management develop job descriptions and propose changes to reflect disciplines</td>
</tr>
<tr>
<td>CPHC duties and accountabilities in job descriptions</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>CPHC duties and accountabilities in job descriptions</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>CPHC duties and accountabilities in job descriptions</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td><strong>Staff performance indicators</strong></td>
<td>Limited reference to primary health care philosophy</td>
<td>Staff performance indicators incorporate primary health care philosophy into health promotion</td>
</tr>
<tr>
<td>Staff performance indicators</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Staff performance indicators</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Staff performance indicators</td>
<td>7</td>
<td>8</td>
</tr>
</tbody>
</table>

Impact evaluation of a CPHC ODS on a health service’s capacity to deliver public health care
### Direction and support for staff in CPHC

<table>
<thead>
<tr>
<th></th>
<th>Limited direction and support</th>
<th>Informal direction and support</th>
<th>Frequent planning, reflective team opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

### External Environment

<table>
<thead>
<tr>
<th>Community input</th>
<th>Limited or inappropriate consultation processes</th>
<th>Frequent evaluation of services and programs</th>
<th>Built into formal evaluation processes, policies and procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key stakeholders</th>
<th>Limited or inappropriate consultation processes</th>
<th>Frequent evaluation of services and programs</th>
<th>Input built into formal evaluation processes and policies/procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

*Thank you very much for your time*
## Appendix 10: Results of CIF 37 indicators within CPHC ODS components and sub components

<table>
<thead>
<tr>
<th>CPHC ODS Component</th>
<th>CPHC ODS sub component</th>
<th>Indicators</th>
<th>t</th>
<th>p</th>
<th>d</th>
<th>Categorical change*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Workforce development</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Opportunities</td>
<td>1. Staff able/ supported to conduct CPHC</td>
<td>3.402</td>
<td>0.004</td>
<td>1.7(L)</td>
<td>R-HP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Direction and support for staff in CPHC</td>
<td>2.657</td>
<td>0.018</td>
<td>1.3(L)</td>
<td>P-HP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Professional development opportunities</td>
<td>2.423</td>
<td>0.039</td>
<td>1.3(L)</td>
<td>P-HP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Task Requirements</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. CPHC Duties and accountabilities in job description</td>
<td>6.966</td>
<td>0.000</td>
<td>3.4(VL)</td>
<td>R-HP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. Performance indicators incorporate CPHC</td>
<td>4.398</td>
<td>0.001</td>
<td>2.2(VL)</td>
<td>R-HP</td>
</tr>
<tr>
<td></td>
<td>Organisational systems</td>
<td>6. Communication direction</td>
<td>1.385</td>
<td>0.186</td>
<td>0.7(M)</td>
<td>P-HP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7. Reference to CPHC in policies</td>
<td>3.902</td>
<td>0.002</td>
<td>2.0(VL)</td>
<td>R-HP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8. Support for health promotion program planning</td>
<td>2.011</td>
<td>0.064</td>
<td>1.2(L)</td>
<td>P-HP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9. Whole-of-team meetings inclusion of CPHC and health promotion</td>
<td>3.819</td>
<td>0.002</td>
<td>2.2(VL)</td>
<td>P-HP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10. Type of quality improvement within programs</td>
<td>4.654</td>
<td>0.000</td>
<td>2.4(VL)</td>
<td>R-HP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>11. Reflection on program goal and objectives aligned with CPHC principles</td>
<td>6.413</td>
<td>0.000</td>
<td>3.2(VL)</td>
<td>R-HP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>12. Process for determining program priorities</td>
<td>4.571</td>
<td>0.000</td>
<td>2.3(VL)</td>
<td>P-HP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>13. Reward systems for achievements in CPHC work</td>
<td>3.063</td>
<td>0.008</td>
<td>1.5(L)</td>
<td>P-HP</td>
</tr>
<tr>
<td></td>
<td>Organisational structures</td>
<td>14. Organisational structures and systems to support health promotion</td>
<td>6.037</td>
<td>0.000</td>
<td>2.9(VL)</td>
<td>R-HP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>15. Health promotion human resources</td>
<td>3.845</td>
<td>0.002</td>
<td>1.9(L)</td>
<td>R-HP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>16. Organisation’s approach to collaboration</td>
<td>2.244</td>
<td>0.042</td>
<td>1.1(M)</td>
<td>P-HP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>17. Nature of organisation’s structure</td>
<td>3.115</td>
<td>0.007</td>
<td>1.5(L)</td>
<td>P-HP</td>
</tr>
<tr>
<td></td>
<td>Organisational leadership</td>
<td>18. Management style</td>
<td>4.426</td>
<td>0.001</td>
<td>2.3(VL)</td>
<td>R-HP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>19. Management practices</td>
<td>2.822</td>
<td>0.014</td>
<td>1.5(L)</td>
<td>P-HP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20. Planning processes conducted by managers</td>
<td>2.896</td>
<td>0.013</td>
<td>1.5(L)</td>
<td>P-HP</td>
</tr>
<tr>
<td></td>
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<td>21. Management understanding of health</td>
<td>1.968</td>
<td>0.086</td>
<td>1.1(M)</td>
<td>P-HP</td>
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<td></td>
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<td>22. Management’s motivation for CPHC work</td>
<td>3.254</td>
<td>0.006</td>
<td>1.6(L)</td>
<td>R-HP</td>
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<tr>
<td></td>
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<td>23. Leadership in CPHC</td>
<td>3.905</td>
<td>0.001</td>
<td>1.9(L)</td>
<td>P-HP</td>
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<tr>
<td></td>
<td>External Environment</td>
<td>24. Consultation processes with community</td>
<td>2.631</td>
<td>0.020</td>
<td>1.4(L)</td>
<td>R-P</td>
</tr>
<tr>
<td></td>
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<td>25. Consultation processes with key stakeholders</td>
<td>2.567</td>
<td>0.022</td>
<td>1.3(L)</td>
<td>R-P</td>
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</tbody>
</table>
### Appendix 10 Cont.

<table>
<thead>
<tr>
<th>CPHC ODS Component</th>
<th>CPHC ODS sub component</th>
<th>Indicators</th>
<th>Time point: Pre – Post</th>
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</thead>
<tbody>
<tr>
<td><strong>Organisational Culture</strong></td>
<td>Overall view of the organisation</td>
<td>26. Mission and Strategy</td>
<td>t = 2.980, p = 0.011, d = 1.8 (L)</td>
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<td></td>
<td>27. Strategic Direction</td>
<td>t = 5.216, p = 0.000, d = 2.9 (VL)</td>
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<td>28. Level of care</td>
<td>t = 7.000, p = 0.000, d = 5.3 (NP)</td>
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<td>29. Focus of activity</td>
<td>t = 3.578, p = 0.003, d = 1.8 (L)</td>
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<td>30. Accountability</td>
<td>t = 1.936, p = 0.075, d = 0.9 (M)</td>
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<td>31. Morale</td>
<td>t = 0.974, p = 0.346, d = 0.5 (S)</td>
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<td>32. Organisational values</td>
<td>t = 0.633, p = 0.536, d = 0.3 (S)</td>
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<td>33. Organisation’s response to change</td>
<td>t = 4.094, p = 0.001, d = 2.0 (VL)</td>
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<td>34. Organisation’s response to success and achievement in CPHC</td>
<td>t = 4.000, p = 0.004, d = 2.7 (VL)</td>
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<tr>
<td><strong>35. Organisational culture</strong></td>
<td>36. Health promotion program focus</td>
<td>t = 3.537, p = 0.003, d = 2.0 (VL)</td>
<td>R-HP</td>
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<td>37. History of health promotion in the organisation</td>
<td>t = 3.819, p = 0.002, d = 1.9 (L)</td>
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<td>38. Attitudes towards health promotion</td>
<td>t = 4.000, p = 0.004, d = 2.7 (VL)</td>
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</tbody>
</table>

*R-P = mean score for indicator changed from Reactive category to Proactive category, P-HP = Proactive to High Performing, R-HP = Reactive to High Performing*