Health Promotion in PHOs, National Networking Hui
19 & 20 June 2006

Perhaps a summary theme statement for the National Networking Hui for Health Promotion in PHOs could be

‘Unity amid Diversity’.

This hui was the first opportunity since the Primary Focus Conference in March 2005 for those involved with health promotion in PHOs to network and share their experiences of the PHO journey. It was not a formal conference as such, and this document is not formal ‘proceedings’ from the gathering, but rather a summary of notes taken to capture the key themes from the discussions that took place. The attached draft paper on workforce development for health promotion in PHOs is a more formal expression of some of the issues raised (see further below).

Over 90 people from 43 of the country’s 81 PHOs were represented at the hui. While those present came from a wide range of PHOs, smaller PHOs predominated in those not represented. There were also some staff present from DHBs, PHUs and the Ministry of Health who work in a variety of roles related to health promotion in PHOs. The hui was a mixture of presentations that were essentially discussion starters, with subsequent large and small group discussions.

There were several clear, key messages coming through the feedback from group workshops and in the questions and comments made in the large group sessions at the hui:

1. People whose work is related to health promotion in PHOs are passionate about reducing inequalities. This by definition will involve addressing the wider determinants of health and working closely with the community, particularly those with demonstrable high need – Māori and Pacific populations and those living in socioeconomically deprived areas (currently defined as Quintile 5). There are seen to be many well recognised reasons to reduce inequalities, including a moral and ethical obligation to do so, and the good will for action is strong in the workforce; however there remain structural barriers to be addressed, not least appropriate workforce development and funding to support this action.

2. While it is vital that a variety of approaches is supported to best address the needs of each unique community, there is a clear call for strategic national leadership, coordination and support for health promotion in PHOs.

3. There is a tension between committing resource to working with the community, but also recognising the unique setting of health promotion in PHOs and its potential to help those working in clinical services understand ‘health promoting ways of working and thinking’ and how these complement, and might be integrated with, personal health care service approaches.

4. The current model for allocating health promotion funding to PHOs does not sufficiently recognise the importance of working with high need communities, and needs revision to better weight the allocation to PHOs serving these communities. In many cases this is related to the size of PHOs and the fact that small PHOs with very limited health promotion budgets are often serving very high needs populations, but this is not always so. The total size of the health promotion in PHOs funding pool was also questioned.

5. A strong call was made for nationally coordinated workforce development initiatives that support high quality, reflective health promotion practice. This call is highlighted and more formally expressed in the attached discussion paper. The recommendations of the paper were generated from hui group workshops that were specifically asked to consider issues related to workforce development to strengthen health promotion practice in PHOs.

Summary notes from Hui Activities

Ministry of Health: The Intent of the Health Promotion Funding Stream in PHOs

Brief presentations were given by representatives from the Public Health Directorate (Maggie McGregor), Leading for Outcomes team (Richard McLachlan) and the Clinical Services Directorate (Stephen Jacobs & Anne O'Brien) – see powerpoints attached.

Key Messages:

1. PHOs are charged with improving the health of populations and decreasing inequalities and therefore by definition should be moving towards being Health Promoting organisations. Health promotion is not in PHOs by accident but as an essential part of the spectrum of work needed to achieve the goals of the Primary Health Care Strategy.

2. PHO health promotion programmes need the same level of planning and evaluation as any health promotion programme but also require attention to the primary care environment – there is therefore a much closer relationship between health promotion and treatment services than is usually the case. This is about the fifth strand of the Ottawa Charter. Reviewing the Alma Ata Declaration is a good place to start in thinking about primary care.

3. The challenges to health promoters in PHOs therefore include
    a. becoming more familiar with techniques used in clinical settings (e.g. brief interventions, screening, immunisations) to ensure complementary approaches working alongside clinical services
    b. encouraging the PHO to take wider approach. This may mean getting the most impact from the health promotion funding by building health promotion capacity in the PHO and integrating this with other PHO activities. "Think strategically to use small dollars to help steer the ship".
    c. Utilising the opportunities presented by individuals presenting in clinical settings as 'portals' to their wider context in the community.

4. The joint MoH/DHB workplan, which includes discussion about the devolution of health promotion in PHOs funding to DHBs, is about clarifying roles - what is every party expected to do – MoH, DHBs, PHOs, not anything to do with changing funding amounts. The health promotion component of devolution relates only to the <u>PHO</u> health promotion funding, not the health promotion funding in public health services.

Key issues in questions/comments from the floor:

Is the $50,000 per DHB funding support for Health Promotion in PHOs expected to continue? Response: not past the current contract.

KPIs for the PHO Performance Management Programme – when is the next part of that to be developed? Phase 2 next year – will focus on cardiovascular risk assessment, disease register indicators. Floor comments – that is still disease prevention focused and we need health promotion indicators. Also if going to risk assess, need to have follow up so there are implications for primary care workload, especially for nurses – highlights the need to understand the context of primary care.

Additional comment: there is a need for guidelines to be strengthened around health promotion in PHOs before devolution so there is some consistency nationally.

The scope of HP in PHOs – what is happening out there?

Discussion Starter: **Example of a regional Guidelines process** – see attached powerpoint presentation.
This presentation briefly outlined a regional process involving PHOs and DHBs in the wider Auckland area to try to establish shared understandings about what health promotion in PHOs might actually look like. This resulted in the formation of regional Guidelines for health promotion in PHOs, which contain a set of operational principles, along with examples of suggested activities. (The Guidelines are available at www.arphs.govt.nz/publications/PHO/Guide_for_HP_PlanningActions_in_PHOs.pdf).

Feedback from workshops: The scope of HP in PHOs – what is happening out there?
Workshop groups were split according to region, with DHB/MoH people together in separate group. Groups were Northland/wider Auckland, Waikato/Lakes/BOP, Mid Central/Hawkes Bay/Whanganui/ Wairarapa, Hutt/Capital & Coast, South Island). The feedback from the different groups was collated into one combined summary below.

This first group discussion session reported below highlighted a number of ongoing issues related to the practical implementation of health promotion in PHOs; subsequent sessions focused on the opportunities provided by health promotion in the PHO setting and looking for solutions for the issues raised.

1. What is the scope of HP in PHOs in your region?

The scope of health promotion activities in PHOs is right across the continuum from screening to policy level activities (as outlined in previous Ministry of Health documents[1]), but in the main focused on the areas of social marketing, settings, community action, supportive environments, and reorienting health services. Quite a lot of health education is happening in some areas but it is accepted that is a place to start to engage primary care practitioners in wider initiatives. Other types of health promotion – HEHA/smoking focus - use an individual approach but acknowledge that is part of a wider whanau ora approach.

Following on from MoH address: is the focus to be programmes in the community or working with primary care practices (this is the first time many have heard the message articulated by the Ministry about the priority of reorientation of health services work). Even in capacity building, is the target to be providers or community agencies? There is still need for more clarity about appropriate health promotion approaches in PHOs.

Capacity building is an issue of resourcing for smaller PHOs, especially sustaining that capacity.

2. How does the content of the Guidelines developed in the wider Auckland region sit with what is happening in your world?

The need for Guidelines has not yet arisen for some PHOs; they have not been on the journey long and are still assessing their capacity building needs. For those that are ready the Guidelines seem logical and do fit.

3. What issues does the scope of health promotion in PHOs raise?

1. Addressing inequalities is an overriding priority. The funding model may not be conducive to achieving this. Part-time staff impact on the work that can be done. Some participants felt that PHOs in general don't fully understand what reducing inequalities is about (Eg. PHO Boards need to be clear that Services to Improve Access / Health Promotion are about high needs populations). There may be innovative ways

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[1] See Appendix One. Also documents on the Ministry of Health Website: Guide to Developing Health Promotion Programmes in Primary Health Care Settings, Public Health in a Primary Health Care Setting, A Bird's Eye View of Public Health (www.moh.govt.nz/pho).

to decrease inequalities but this will require clear planning and monitoring. Silo funding in PHOs doesn't really help – there needs to be a lot of interlinking of SIA and HP but there is siloed delivery and reporting.

2. There needs to be better understanding of Māori models of health and health promotion (e.g. Te Pae Mahutonga) and use of them to plan and develop measures around those models.

3. Should the focus be on the enrolled population or the wider community (more of an issue in urban communities where there may be 4 or 5 PHOs all servicing the same geographic area)? Where do we start and stop?

4. There is a need to clarify the terms health promotion and population health, and the roles of health promotion in a PHO (e.g. can advocate for NGO funding, outcomes focus, inequalities).

5. If PHOs are subcontracting all their health promotion funding that funding may not achieve reorientation of primary care.

6. There is a lack of awareness by clinical staff of what health promotion actually is – health promoters do need to become familiar with clinical practices but this needs to be reciprocated. Funding and support is needed to support trying to change attitudes of clinicians. Practice nurses often have capability but don't have time.

7. The make up of PHO Boards varies quite a lot – some are very doctor led, others have whole range of members and consensus decision making. There is a real challenge keeping health promotion a priority in terms of other priorities in PHOs, especially given the small size of the funding stream relative to other PHO funding. It was suggested that the Te Waipounamu resource on health promotion should be read by all Boards and managers (available in hard copy; contact www.hpforum.org.nz/twhpc/).

8. There are tensions in relationships with DHBs, especially around priorities, and concern was expressed about whether all those making decisions about signing off PHO health promotion plans actually have the knowledge and expertise to make those decisions. Some are concerned about devolution of responsibility for health promotion in PHOs to DHBs for this reason. It was suggested that the MoH needs to have criteria around who is employed in DHBs to support health promotion in PHOs – the workforce needs to be well supported. Does each DHB need to have 'population health type' people in their Funding & Planning division? Funding & Planning cycles for one year at a time present real challenges for health promotion, producing unrealistic expectations for health promotion outcomes over such a short time.

9. MoH also need to give PHOs guidance about health promotion employees – what are appropriate KPIs, skills and knowledge necessary, career paths.

10. Health promoters in PHOs need to be strategic about the wording of priorities so they can address on the ground issues as well as top down priorities. Deciding how best to make the right impact within many issues is a challenge for priority setting.

11 There is need for support to develop an evidence base and appropriate baseline indicators for health promotion in primary care - how do we measure outcomes appropriately; this needs better guidance and support from MoH. The performance indicators of the PHO Performance Programme really only support the development of general practice; how does wider primary provider development fit within PHOs? How can we involve clients in setting KPIs?

12. In one group 3 different programmes were being developed for education of primary care providers – do we need consistency from MoH around what is happening with that?

13. Collaboration: with other PHOs and wider with regional Public Health Units and NGOs – needs to occur but needs leadership and capacity to make that happen. The challenge for local authorities, who are a key stakeholder in rural regions, when there are six different PHOs in a region was raised, highlighting the need for collaboration between PHOs. When formalising partnership arrangements for

service provision, DHBs need to know there is not duplication of the funding that they already paying to other providers for health promotion services.

14. NGOs and where they fit – currently they may be represented in PHO governance and health promotion sub groups, but GP providers are the ones who are accountable for the KPIs and not the NGOs. There are examples of good collaboration where NGOs and PHOs are working well together, but some NGOs see PHOs as competition. There is a need for 'rules of the game' to give clarity to roles so that PHOs are not seen as competitive. One advantage of PHO funding is that it can often be more flexible to address wider determinants and community groups than NGO funding.

15. In some areas the Public Health Unit may be contracted to provide quite extensive support to PHOs including facilitating regular forums of health promoters from PHOs in the region and providing training using the '50k' funding[2]; ability to maintain this will be very limited if that funding is not available going forward. Information is not available for all DHBs as to what arrangements have been made for the use of this funding, and some may not have accepted the contract for it.

16. The Primary Health Care Strategy Implementation Work Programme 2005 - 2010, which includes the devolution of PHO health promotion funding to DHBs, needs PHO representation, and in relation to decisions about the health promotion funding stream this needs to be someone with health promotion expertise who has actually been integrally involved in health promotion in PHO issues.

17. IPAs and how they fit with PHOs varies across the nation. DHB's relationships directly with PHOs may cause tensions for some health promotion workers who are employed by the IPA providing management support for the PHO. As reiterated later, IPAs do still exist and there is a need to continue to explore ways to constructively work with them.

18. It takes resource and skill to share information about the learning journey of health promotion in PHOs. One option would be to fund action research pilots with external evaluation, with sharing of subsequent information. The content of these pilots could move over time to much broader issues but could start reasonably close to clinical paradigms to enhance buy in across the professional groupings of the PHO.

Creating a Supportive Environment for HP in PHOs:

Discussion Starter: The Setting of Primary Care – how is it unique? - see attached powerpoint. This presentation briefly reviewed the diversity of PHOs that have been established across the country, the changes across the primary care sector over the last 15 years that are important context for the current realities of PHO functioning, and the potential opportunities presented by the positioning of health promotion alongside primary care clinical services in PHOs.

Feedback from workshops: Creating a Supportive Environment for HP in PHOs
Groups were split to try to give an opportunity for those in PHOs with similar backgrounds and demographics a chance to discuss issues together e.g. previously IPA based & urban, previously IPA based & rural, Māori, mixed including Health Care Aotearoa background. The feedback from the different groups was collated into one combined summary below, but with the issues raised by the Māori and rural PHOs groups noted separately.

What does it mean to create a supportive environment to maximise the opportunities presented by the setting of primary care?

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[2] Annual funding of $50,000 has been offered to DHBs to provide support for the development of health promotion in PHOs but DHBs have varied in their arrangements for delivering this support

1. Effective relationship management is key to identifying gaps and opportunities.

2. Identify key people who can support health promotion / partnerships. Utilise the local PHU to support work.

3. Find health promotion success stories and share them to increase buy in from clinics / community; find champions. Do we need to change our language? – we're 'adding value', 'creating ownership'.

4. KISS – health promotion practice and data collection needs to be part of daily practice of primary providers, not an extra ask of them.

5. It was suggested that if we are asking practice staff to do more work someone needs to pay them to do it, including paying them for training.

6. Train the trainer models are useful for education eg. for nurses. Some suggest focusing on practice nurses rather than GPs, at least initially as they are more likely to be receptive.

7. Health promotion KPIs are needed in the performance objectives of staff (other than health promoters)

8. There is a need for a fulltime, dedicated workforce - part time workers (the constraint being funding) are finding it difficult to be effective.

9. We need to find ways to highlight benefits of working in primary care setting to new grads of all disciplines.

10. IPAs still exist; we need to find ways to constructively work with them with better definition of roles.

11. Community engagement is important. Some suggested it may be more challenging for larger PHOs to be really connected to communities; this view itself was challenged. This does raise the issue of whether PHOs are being audited for community involvement.

12. There is a major need for national coordination of health promotion efforts in PHOs – not to tell PHOs what to do but to enable it to happen. MoH needs to fund central coordination, assist in setting up an electronic network, possibly a managed website, and annual workshops. There needs to be a consistent health promotion in primary care training package. Possibly PHONZ/ HPF/PHA could be involved, and we certainly need a workstream on health promotion in PHOs at their conferences. Email links are a fairly easy way for all to keep in touch after the hui – all need to make commitment when they go back to keep in touch, set up email lists.

13. PHO roles in decreasing inequality – there needs to be more money into areas of high need. How we do that was debated. Do we create positions in Māori organisations by collaborating across larger PHOs with funding? Could there be a regional pool of PHO health promotion funding, and weight it to organisations with higher need (rather than directly into PHO) but this wouldn't give potential to reorient the other PHOs.

14. Specific issues from Māori PHOs:

- There is a difference in terms of level playing fields. PHOs didn't have the same start – Māori PHOs frequently had to start from scratch compared to PHOs established by groups with previous investment in IT and systems infrastructure. Funding is actually very small for Māori providers even though they are a huge force in the community – Māori Health & Disability funding < 3% total health spend. There needs to be equitable needs based funding
- The PHO Treaty claim - how do we deal with history? All health promoters should understand the ToW in a real sense.

- Looking at and valuing models of health for Māori e.g. Te Pae Mahutonga as a way to begin to understand what inequalities are about.
- Te Reo – being able to say names correctly even if can't speak fluently.
- What does best practice actually mean for Māori?
- Capacity building and workforce development - by Māori and for everyone
- There can be a perception that Māori can't do it. There are lots of racial undercurrents in the health field; how do we deal with that?
- There is poor understanding by mainstream of Māori service delivery.
- We need to value the community by understanding their realities
- Tino rangitiratanga – is about self determination. Are we really doing for Māori what we say we are doing?
- Examine within ourselves – are we really part of the answer or the problem
- It comes back to the Treaty; lot of what is being said is not new; it has been done over the last 15 years.

15. Challenges for rural PHOs:
    - Expectations from rural communities about what PHO can actually provide may not be realistic. We need to disseminate information about what a PHO is.
    - There may not be many other services to collaborate with.
    - PHOs often cover large geographical areas, and many PHOs are virtual – getting Boards together effectively is challenging.
    - Need to be careful with consultation to make sure we are actually capturing all areas.
    - ? DHB could lead collaboration of TLAs, PHOs, etc in geographical areas
    - Workforce retention issues in rural areas for primary care providers, so continuity issues.
    - Transient non-enrolled populations – seasonal workers. Many GPs have closed books, so can't enrol new patients. Needs MoH/DHB discussion about how to address inequality issues in these areas. One potential way for transient workers is to collaborate with industry providers eg. Orchardists, ski fields.

Day Two

Workforce Development for leading Health Promotion in PHOs

1. How do the issues for health promotion in PHOs fit with wider Health Promotion workforce development activities?

(Maggie McGregor, Ministry of Health)

- at the time of distribution of these documents the powerpoint summarising this address was not available but the key messages are outlined below.

Key messages:

The public health workforce is currently largely unregulated and fragmented. It is enriched by the number of people working in it who are from professional groups other than traditional health professions, many of whom have a tertiary qualification but not one specific to public health. However going forward the MoH will be saying quite clearly, that is not enough. Those employed to positions designated as public health/health promotion will need to be trained in public health/health promotion or be prepared to enter such a training pathway; that includes health promotion positions in PHOs.

This raises a number of issues, which there are plans to address:

1. There will be consultation on generic public health competencies over the next year and the decision made on how to use those in the future.
2. At present a relatively high percentage of the public health workforce identify as Māori but the majority are working in relatively low level positions. There are plans to strengthen this workforce and Te Rau Matatini have been contracted to progress this; it is important to highlight PHO needs to them.
3. There is a recognised need for the development of a national training and qualifications framework, with a particular gap in health promotion. It is believed those working in health promotion need to have, or be working to gain, at minimum early entry level training but to be aiming for Diploma level and moving on to Postgraduate study. This requires a good staircase with bridging options for those who are working in the sector but not studied previously. It is also recognised that academic education alone is not sufficient, skills and competencies also being required.
4. Increasingly those working in public health are being required to provide key leadership for good public health practice in non-health settings. Many working in PHOs are a good example - trying to 'steer the ship' and not had the opportunity for leadership training. Various options to give people these opportunities are being explored e.g. mentoring, the LAMPS programme, scholarships.
5. There is a lack of professional bodies for the public health workforce - Public Health Medicine specialists are really the only group with a strong professional body, and there are only two other groups regulated by the HPCAA, public health nurses and dieticians, neither of whom have a strong public health component to their current structures. Health protection and health promotion have been identified as priority areas for development in this area. Some of the questions this raises are
    a. are we talking about the need for a professional body for health promotion (and health protection) or just better career pathways?
    b. do we need to think about a multidisciplinary professional body as we are quite a small workforce overall and perhaps could have a stronger voice if we worked together better? The group working on the generic competencies may recommend that.
6. Public health in primary care: the health promotion in PHOs workforce is key in this area. Again there are a number of related areas, and various pieces of work of work going on but this needs pulling together:
    a. Is health promotion in primary care the same as health promotion in other arenas, just working in a different setting?
    b. This setting requires a much more thorough knowledge of the personal health care sector than that required for other health promotion activities
    c. What training do other health professionals working in the PHO setting need about public health and health promotion?
7. How do we plan for the public health workforce going forward; we can't count admissions etc, so how do we quantify needs for future planning?

A key question is: how do we keep an identity that is organic but recognise skills and competencies that are important for our work?

The New Zealand Primary Health Care Strategy was presented at the Bangkok Health Promotion Conference in 2005 as an example of the potential to reorient a whole health system to health gain, and health promotion in PHOs is a critical part of that.

Comment from the floor supporting professional development: Right now workers are crying out for basic training. We are charged with professional and ethical responsibilities to fulfil contracts and we need to recognise the struggles. We might not be killing people on an operating table because of lack of competency but we are potentially killing people nevertheless – people are dying from diseases we are trying to prevent.

2. Invitation to the floor – what initiatives are happening in workforce development for HP in PHOs around the country?

The following were not formal presentations but an opportunity to share what people are doing across the different regions. These notes are a brief summary of what was shared. It needs to be born in mind that time constraints and the fact that not all PHOs were represented at the hui mean this is likely to be a limited view of the wider picture of current workforce development initiatives for health promotion in PHOs.

(a) Debbie Petersen, Waikato PHO:
The PHO didn't want to build capacity within so looked at how they could support people working in the sector. From talking with Māori and Pacific workers and those in NGOs, it was identified that many were having to get straight on with doing the job of whoever was in the position before them without the opportunity for initial training. In response to this identified need, Hine Martin was contracted to run a two-day Introduction to Health Promotion basic training. 3 courses have been run, attended by about 20 – 25 people each time. These people have been encouraged to go on to do other health promotion study but again it was identified that smaller PHOs and Māori providers often didn't have enough funding to support future study so the PHO has developed a number of scholarships to support them to undertake the Certificate in Health Promotion from Otago University. Currently 6 people are studying this concurrently and have built a local support network for themselves.
Hine has also recently run a 2-day planning and evaluation workshop; those who had done the Intro workshops were invited back to this. Four 2 hour training sessions on health determinants have also been offered to PHO staff and community groups.
All this has been funded from the PHO health promotion budget.

(b) Ada Wanoa-Armstrong – Procare Network PHOs, greater Auckland region
The 3 Procare PHOs in the wider Auckland region have a team of 7 health promotion advisors, 5 Māori and 2 Pacific, working under a health promotion manager. Several of these advisors have many years experience in health promotion, some hold MPH or Dip Pub Health, and 3 are enrolling in further health promotion study at Auckland University. As a team the advisors are working to support Māori providers in the community and help resource them. Te Puni Kokiri have also helped with some of their strategic planning, with an emphasis on whanau ora work. Reflective practice is being supported.
Also GP/practice nurse cell groups are used to discuss the concept of health promoting practices and to develop this further.
The Procare Network Manukau PHO is also working with other PHOs in the area to develop a collaborative plan for Counties Manukau, with regular meetings to which the PHU contribute.

(c) Otago (information provided by Chrystal Greenwood, Public Health South)
Have had access to Jigsaw training (through local PHU) because it was MoH funded. If wasn't MoH funded, it would be provided at the expense of human resource on the ground (similarly without MoH funding PHOs would struggle to be involved in forums like this National Hui).
Jigsaw is a 5 day course, developed for people in PHUs, in a modular format – Treaty of Waitangi, determinants, programme planning etc. Yet to tease out what aspects are most relevant to PHO Boards and try to get it down to 3 hours for them.

(d) **Ngaire Rae, Manaia PHO, Whangarei**
(geographic area covered is same as TLA, approximately 76,000 enrolled population).
Has developed 8 week course, 2 hrs per week, for practice nurses about health promotion, in conjunction with Julie Palmer, nursing integration leader pilot worker (MoH funded). Developed in close collaboration with the nurses themselves.
Start with food at 5.30pm so can come from work. 16 enrolled, 13 completed. A folder of readings is given out each week to cover the theory and the practice of that is discussed the next week. A template has been developed for health promotion plans, which from week 3 or 4 has been used as a guide for the lesson. Reflection encouraged by giving them each a journal; encouraged them to have a question each week. Each evening started with discussing their reflective questions in groups so starting with where

they were at, not just didactic teaching. Have shared the opening and closing of each session with participants and encouraged group work as a health promotion way of working.
Topics covered include: what is health promotion, how is it different from health education, Maori Health, determinants, inequalities, health promotion in primary care, project planning and evaluation. Used guest speakers. Realised one challenge was that they are encouraging nurses to work in empowering way while they are often a relatively disempowered work force.
Aim by the end of the course is that each nurse would have planned a health promotion project in primary care; now working with them and their practices to implement and evaluate. For example one nurse is doing a literature review on oral health promotion in primary care to better inform what they should do – the PHO is funding her to do that; 3 nurses from a practice in distinct geographical area (Onerahi) are working with the community to set up a healthy Onerahi team.
Overall result is there is now a network of nurses who are linked up as a special interest group. There is ongoing needs assessment, with discussion at week 6 to determine how best to provide support going forward.
Outcomes – one nurse talked about how she 'now sees things differently in her practice work'; stronger links have been built by the nurses with their community.
The team of Ngaire as a health promoter and Julie as a nurse has been vital to making it work, along with working closely with the nurses themselves. Also paying the practice nurses for their time.

(e) Jessica Hintz, Ali Oldershaw, Capital PHO
(34 medical practices, 134 000 enrolled population).
Health promoter employed part-time to undertake Health Promoting Practices project. Surveyed practice staff, and visited them. As a result private contractors Quigley and Watts and the Wellington School of Medicine have contracted together to provide a one off session for practices covering what health promotion is and how it is related to primary care, and are now building 5 week course based on Whangarei model. Invitations were sent to whole practice teams and PHO Boards but found nurses and GPs attended but not receptionists or people from the Board. The PHO health promotion budget is funding attendance and back filling time in practices when the 5 week course is run. There is linking of training to CME/CNE points.

(f) Clare Munro, Health promotion advisor, Regional Public Health, Hutt Valley
PHOs in the area are looking at different models; some are training staff as above, some are wanting something more formally accredited, another is looking at using WINZ cadetships as a way of supporting people to get into health promotion. The question is do we need to establish something more consistent, and funding is an issue – without the $50k contract some of the support for these initiatives would not be available.

(g) Jane Kinsey, Nelson Bays PHO
(mixed population, about 40,000 urban, 40,000 rural)
The PHO Board are keen to support health promotion but running a training programme didn't sit well – health promotion wasn't seen as relevant to people in PHOs, and still seemed health promotion in primary care was unknown quantity. Decided there are a lot of presumptions about what practice nurses and GPs do know – some of them do understand stuff but there are a lot of organisational barriers; need to think about what we are asking them to do in their world. Currently have employed a practice nurse to work with other nurses to find out what they think being healthy actually is. Working with the DHB on practice nurse education, looking at their own practices but also wider primary care nursing.
Also working with Māori providers in Nelson, trying to interface the Māori providers with mainstream providers in peer groups etc. Also have a Be Well project – capacity building. Instead of asking PHO providers to change their practice, are trying to create customer demand. Have developed a handout people can give to their provider to encourage them to think about wellness; questions on lifestyle. Also trying to get workers out of their primary care setting into the community, practice nurses and kaiawhina workers to address people's issues can go to workplaces, rugby clubs to link them to services. Currently funded from health promotion – Board very protective of SIA dollars.

(h) Ana Apatu, Heart Foundation employed to deliver health promotion for Hawkes Bay PHO.
Struggled to think about whether general practice is the best setting for health promotion.
Gap analysis demonstrated that Māori providers and NGOs were lacking in workforce development opportunities; often delivering nutrition and physical activity programmes without training. So the PHO has funded National Heart Foundation Māori arm to deliver training, with very positive feedback. Planning to run further training in 6 months and see how it's influenced practice.
An important question is are the PHOs to be providers, or to strengthen what is already going on, particularly with Māori providers? The Māori providers know the answers for their communities, but patch protection in primary care is an issue.
Have also hosted Quit smoking training – lot of NGOs, Green Prescription people attended.

Weitske Cloo, health promotion advisor Hawkes Bay DHB. Also have 2 smaller PHOs in the area. The combined training has been helpful in breaking down barriers between existing providers.

(i) Pacific PHOs:
Soana Muimuiheata, Ta Pasifika in Counties Manukau. Small PHO so health promotion budget doesn't even fund a position. A public health registrar developed good plan but ongoing capacity issues made it difficult to deliver it. Challenge to differ between health education and health promotion, and then no resource to address community issues. The Pacific perspective is that health promotion doesn't come with a career but with the community. As a qualified professional in the community, you are working all the time with churches and the community but not as part of your contract. Also recognise young people may not be connected with their community. Real challenge to develop a framework; everyone has their own agenda and contract.
Villiami Toafa, Pasifika Healthcare. Pasifika is a sole Pacific provider in a larger PHO (Health West). Health promotion has always been part of the package for this provider, long before general practice services were offered, starting with cervical screening. They talk about practices accessing the community rather than community accessing the practice – use the community connections as a means of getting the message across. Had problems with language – multiple different Pacific languages - so recruited a number of ethnic specific people fluent in their own language and then the practice had to train these people to deliver health promotion. The practices became supporters for health promoters not the other way round, and Pasifika Healthcare actually employ more health promoters than the PHO itself. However the PHO is able to afford a bus to do mobile screening for diabetes and cardiovascular systems disease.
One issue is do we make people more multiskilled or try to employ social workers etc? Community Health Worker training is available in Auckland but although part of the National Qualifications Framework, is not NZQA accredited.

Affirmed from the floor for taking the view that need to resource what is already going on in community – sits well with Māori providers.

(j) Health Promotion Forum (Dallas Honey & Alison Blaiklock)
HPF is rebuilding and looking at their strategic direction. Two focuses: workforce development and leadership in health promotion and how the Forum can speak on behalf of its membership. Challenge of how to work on Treaty issues which is a significant focus. Now have a Māori reference group, an academic reference group, and a Pacific reference group so broad input into the Forum's functions. Partner with Manukau Institute of Technology to deliver the Health Promotion short course (2 4-day blocks). The demand is much more than the capacity to provide this course and work is going on to work out how the course can provide stair-casing to other education options. However currently education funding rules have changed and trying to work through the issues raised but have had to put the Short Course on hold for the moment. Feedback from the workforce is that people want it delivered around the country but it needs to be quality and linkable to other training, and relevant to people around the country. Also providing various workshops including one on health promotion and primary health care, which was mainly aimed at mainstream health promoters.
Annual conference in Oct. If requesting advice, use www.hpforum.org.nz as contact.

General questions/comments from the floor:
How are practice nurse education courses going to make sustainable change – in some areas there are mostly smaller practices with one nurse who is running all day long because of her workload, without trying to do health promotion projects?
Response that where these projects are happening, the majority of practices are larger with part-time staff who have capacity to do more.

How are we measuring how this is shifting people's practice; what health promotion outcomes are they addressing? What kind of indicators do we have?

Does 16 hours really help people understand what it means to really understand ToW etc? What planning is there for the future to enable people to address this further?
Response: just aims to be a starter to thinking.

Do we need to establish something consistent for practice staff workforce training as there is potential to reinvent the wheel all over the country?

Issues about inconsistency between what DHBs will allow PHOs to fund with their health promotion dollars – in some areas would not consider funding practice staff to attend any training.

Strategies for workforce development for health promotion in PHOs

Brief presentation on request by MoH for summary paper to recommend strategies for workforce development for health promotion in PHOs. Workshop in groups, discussion focused on questions to be addressed for summary paper:

In the context of PHOs: How do we build workforce capacity and capability for Health Promotion in a changing and challenging environment?

- How can strong and diverse leadership in health promotion be developed and promoted?
- How can a strong focus on community development for the health promotion workforce be maintained?
- How can a strong focus on the determinants of health and the reduction of inequalities for the health promotion workforce be developed?
- How can the voice of health promotion within public health and primary health care be strengthened?
- How can access, cohesion and linkages in the development and delivery of health promotion training best be achieved?
- How can competence in the workforce for health promotion be built and ensured?
- How can cultural competence in the workforce for health promotion be built and ensured?
- Are there any other strategies you would recommend to support the development of a well trained workforce for health promotion?

Responses were collated into the draft paper attached, which will be used by as a basis for further consultation by the Ministry of Health to inform workforce development planning related to health promotion in PHOs.

QIPPS – Web-based Health Promotion planning tool

Presentation by Serena Everill, QIPPS Program Director, c/- Australian Institute for Primary Care, La Trobe University, Victoria, Australia

QIPPS is a web based planning & evaluation system that incorporates documentation on health promotion, planning and evaluation, designed by Victorian Community Health Association, a not-for-profit health service in Victoria, Australia. Aims to encourage the development of a systematic approach to health promotion planning and to develop a culture of documenting and evaluating health promotion activities in order to both improve health promotion practice and increase the evidence base for health promotion.

The initial developers recognised that health promoters tend to be 'doers' and that it is a huge shift to get people to reflect and write about their work. Keen to stop everyone reinventing the wheel so QIPPS encourages sharing of plans, organisational structures and policies via a library, which has a brief summary of the projects with contact addresses.

There is ongoing development of a collection of fuller plans, which are publicly available online after being peer reviewed; current criteria for this are - need to involve more than one intervention type and have to target a population not just a group of clients. Three stages to be accepted onto the public database: draft, evaluated, peer reviewed. In the future reviewer' comments may be made available in appendix.

People who work on the ongoing development of QIPPS are from health and community development backgrounds with technical support working alongside. They recognise mentoring and support are just as important as qualifications – QIPPS is only a tool and can gather dust unless people use it.

Using QIPPS requires internet access with an internet browser. Essentially you work on a password protected slice of the website. The planning is saved on the web but can also be saved/exported as Word document. The QIPPS templates are developed in a database format with the capacity to extract data for planning and reporting purposes. They include supportive information, definitions, research material and references, and hyperlinks to important websites. The planning pages have a lot of drop down boxes that give explanations of terms and background to consider when planning and links to evidence bases. The tools are primarily designed for health promotion planning and evaluation purposes, but can also be utilised for a broad range of project plans including treatment-based projects.

PHOs in the wider Auckland region have been offered the opportunity to pilot QIPPS in New Zealand, with local support being provided by Auckland Regional Public Health Service, in addition to online support from Australia. As part of that process, QIPPS now has links to New Zealand information and websites, and are keen to incorporate more NZ literature. Best practice examples have been asked for by Auckland PHOs.

As well as an individual programme planning template QIPPS has also developed an organisation wide planning tool with the capacity to 'talk to' the individual planning tools which gives the opportunity for integrated health promotion planning at the individual, organisational and catchment levels. It provides linkages for people who work at distance – good for rural areas. Has the potential to be able to link plans for personal health care (e.g. SIA) alongside health promotion.

Beyond the NZ PHO pilot? Evaluation of the pilot is due September/October 06. MoH can't dictate to 21 DHBs but MoH sees great potential because people don't have to individually access all the information etc and adds some consistency. The programme reminds you to look at relevant documents and has potential to raise the bar around health promotion planning across the sector. Some Public Health Units are also showing interest – the biggest advantage being it supports the move towards evidence based practice.

Costs are related to the size of the organisation / total expenditure. Cost structure for potential role out in NZ being worked on. In Australia it costs $A700 – 2000 for an annual subscription which includes ongoing helpdesk support. Start up training is provided both in the use of the tool and also health promotion concepts.

(There is also an additional 5 day core health promotion short course available from Victoria which is being investigated as an avenue for training for PHOs in the greater Auckland region while HPF and MIT course being sorted.)

Feedback from Auckland PHOs present: QIPPS gets you really thinking about what you are trying to achieve and how you are going to do it. Prompts and guides your thinking about what a good planning process should involve. Group tutorials and one-on-one mentoring after the initial start up training (provided by ARPHS support staff) have been really helpful. Also has potential to raise respect within the PHO Board because of well presented plans, and the built in quality assurance is another lever for getting management buy in.

Collaboration Across the Sector

This agenda item, with Discussion Starter : NGOs & the Primary Health Care Strategy - a report from the NGO Working Group, was deferred because the workforce discussion needed more time.

Health Promotion in PHOs: National Network Ideas & Roundup

Recap on request at Primary Focus Conference last year and the requests that have come up over the 2 days of the hui:
What are the potential options (e.g. website, regular facilitated forums).
How would it actually work & what would people get out of a national network?
How would we use this network to improve our practice?
Which issues do we need to deal with regionally, which nationally?
What are the appropriate processes?

Identified needs – the following are suggestions from this workshop session of things that could contribute to better support and improved coordination for health promotion in PHOs:

1. National coordination

- needed for workforce development; MoH needs to work with the DHBs
- need some consistency so can learn from each other and share resources, while allowing innovation and flexibility
- Reducing inequalities is an overarching emphasis but there are vast differences in different areas about how this is being approached and need accountability for what people are actually doing for the populations that they are supposed to be targeting. Documents and policy are interpreted by 21 DHBs in 21 different ways so need national coordination and consistency.
- DHBs may be meeting regionally; CEOs meet nationally so think about how we get the issues on their agendas.
- ? potential in the devolution process to develop national guidelines for health promotion in PHOs. Who represents PHO health promotion people in the devolution discussions? It was identified in feedback from the consultation road show about the Primary Health Care Strategy Implementation Work Programme 2005 - 2010 that the voice of PHOs and the community were missing. Anne O'Brien from MoH will seek advice.
- Similarly in the discussion about high performing PHOs and the PHO performance management plan need to have health promotion voice if health promotion is to become an integral part of PHOs.

2. Annual hui as a minimum

- It was suggested this should be organised by MoH with a national planning group; HPF could also be involved
- One possible way to meet the needs of those directly involved in health promotion in PHOs but also involve those in related work, would be to have first day for people directly involved with health promotion in PHOs and second day for those involved in related work e.g. MoH personnel, DHBs, PHUs, NGOs.
- Timing & venue: early May next year was suggested, in Wellington as that is most central
- Theme- ?HEHA ? managing expectations of community alongside top down driven priorities ?collaboration ?workforce development and the formation of a national professional body
- Include time to consider health promotion models that are working in PHOs, and a report on the evaluation of QIPPS
- Could be supplemented with 6 monthly regional huis

3. Handbook constructed for this hui is the first time there has been a list of those involved in health promotion in PHOs. This needs to be updated regularly, ? annually alongside hui. Also could consider whether the network should try to start a health promotion in PHOs publication

4. Electronic bulletin board – could be used to share newsletters, plans that might be useful to share. Who would host and manage, could it be connected to QIPPS if this rolled out more broadly? Michael O'Dea from Partnership Health will put forward synopsis of what could look at and send to Cheryl for dissemination.

5. Challenged to collaborate with each other: seek any potential to strengthen ties with each other and make those connections. Use any strategic opportunities to make others aware of the issues for health promotion in PHOs.

6. Also challenged to advocate for the needs of smaller PHOs who are often working with hard to reach people. Are we stuck with the funding formula or can we ask: what is the minimum health promotion expertise needed in each PHO – 1 FTE per small PHO where working in a high deprivation area? Brian Pointon will consider writing a discussion paper; Chrystal Greenwood will forward on an MoH paper about Size and Capacity in PHOs which demonstrated that size did make difference.

Appendix One

The range of potential activities which could be adopted by PHOs to address population issues occurs on a continuum from those more individually focused to those targeted at the whole population.

Individual focus ⟷ **Population Focus**

Screening, individual risk assessment, immunisation	Health information (person to person communication about health, illness, health services and supports available)	Health education, counselling, and skill development (delivered to individuals or groups, aims to improve knowledge, attitudes, and individual capacity to change)	Social Marketing (persuasive programmes designed to influence the voluntary behaviour of the audience, and/or raise awareness about a health issue, often using media in various forms)	Organisational development (building the capacity of the PHO to be a health promoting organisation[3], includes practice systems, workforce development and strategic allocation of resources to support health promotion)	Settings and supportive environments (aims to improve local living and working conditions so they are more conducive to health)	Community action (working with a community to achieve health outcomes for specific health issues, e.g. diabetes)	Economic and regulatory activities (policy and systems support for promoting health, including financial and legislative incentives or disincentives)

Activities can be linked to the five strands for action of the Ottawa Charter, a key planning framework for health promotion:

Developing personal skills
Strengthening community action
Creating supportive environments
Building healthy public policy
Reorienting health services

PHOs are encouraged to focus their health promotion activities towards the population focus end of the spectrum.

[3] by ensuring policies, priorities and practices apply health promotion principles