

# **Primary Care Clinicians Supporting Health Promotion Project**

Report on Stage One, Consultation.

Doone Winnard,  
for Auckland Regional Public Health Service.

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## **Executive Summary**

The overall aim of this project was to develop champions for a public health and health promotion perspective amongst clinicians and senior management in PHOs in the three DHBs in the Auckland region, by organising a series of five training workshops (2 – 4 hours each) designed to promote team learning. These workshops would be promoted to 'grassroots' clinicians along with those in management or governance in the PHOs, and would also involve the PHOs health promotion advisors. By increasing understanding, it was hoped to increase support for health promotion and the wider public health approach in PHOs, and ensure that health promotion workers and clinicians in PHOs do not operate within disengaged silos.

This report outlines the results of Stage One of the project, entailing consultation with key stakeholders (18 PHOs, the three DHBs and Ministry of Health) to investigate support for, and potential barriers to, the successful implementation of such workshops.

### **Outcome of consultation**

In considering potential barriers to the implementation of the proposed workshops, significant concerns related to wider issues about public health and health promotion in PHOs were raised, which most of those interviewed believe will impact on any education/workforce development proposed, and therefore need to be addressed first. They believe that initiatives to clarify shared working definitions and expectations of PHOs in relation to their implementation of the primary care strategy, population health, health promotion and public health are needed *with some urgency*.

Thereafter, workforce development/education based on these clarified understandings would then be appropriate at a number of levels across the wider PHO setting, with management/ governance level understanding, both in PHOs and DHBs, being a first priority.

It is recognised that the thoughts reflected are those of people working at the coalface of PHO implementation in the Auckland region, and will subsequently need to be reviewed in light of experience and planning at a national level.

Thus, although the intent of Stage Two to increase support for health promotion and the wider public health approach in PHOs was acknowledged by most as necessary and important, it is not felt to be appropriate to continue with the development of the proposed workshops as initially conceived, to be delivered in early 2005, at this point in time.

### **Recommendations**

There are essentially two sets of recommendations in this report. The first is a suggested way forward based on ideas given by those in PHOs to address the concerns they raised as barriers to the current proposal being successful. This way forward is in line with similar views from DHB representatives, and is outlined in more detail in the body of this document. A strengths-based approach, building on the assets offered by all those involved in the sector, is seen to be fundamental to progress.

## A Suggested Way Forward

1. A meeting be held between Ministry representatives from the public health and primary care teams, DHB staff with responsibility for working with PHOs, and representatives from the PHOs, to come to an agreement on definitions and expectations of PHOs in relation to the primary care strategy, population health, health promotion and public health. Suggested definitions have been made in previous Ministry publications (eg Public Health in a Primary Health Care Setting), but it is the practical implementation of these, with subsequent funding implications, which needs increased and shared clarity.
2. This meeting be followed with the establishment of clear, consistent guidelines for what is acceptable use of health promotion funding in PHOs, along with consistent, timely procedures across all DHBs for the sign-off process for health promotion plans. Again these guidelines need to be established in collaboration with those actually working in PHOs, generating shared ownership of the process. Generation of practical tools to assist PHO management is considered important in this process.
3. Once these expectations are clearly delineated, training be initiated for all those immediately effected so that there really is shared understanding
  - a. DHB staff not involved with initial discussions as per 1 above. (eg funding and planning staff)
  - b. PHO Boards / CEOs, emphasising related strategic decision making
  - c. PHO management, emphasising practical operational issues.
  - d. In PHOs where those responsible for health promotion planning and oversight have not had formal health promotion training, more intensive training may be appropriate

In addition, shared understanding initiatives need to include those working in Regional Public Health Services, to support their engagement with PHOs and encourage strong linkages between providers.
4. Once those involved at these levels are then confident of their roles and expectations, it is suggested that training for clinical providers could begin by way of a CPE session provided in the setting of PHO regular educational meetings (eg cell groups).

The second set of recommendations relates to the development of an action plan to progress the intent of the project, to increase support for health promotion and the wider public health approach in PHOs. These recommendations are:

1. **That although the intent of the project is acknowledged as necessary and important, this project does not proceed to Stage Two as initially proposed, at this point in time.**
2. **That the project consultant, and the project sponsor from Auckland Regional Public Health Services meet with Ministry representatives to discuss further the suggested way forward outlined in this report. It is suggested that the discussion to clarify shared working definitions and expectations of PHO activity fundamental to further education initiatives will need to also consider national involvement in this process, the recommendations of the SHORE report (Penney, MacDonald, & Duignan,**

2003), and the potential need to consult with other organisations (eg PHA, College of GPs)

3. That, giving consideration to the outcomes of the above meeting, Auckland Regional Public Health Service develops and implements an action plan to progress the suggested way forward outlined in this report.

### **Acknowledgements**

Thanks to all those consulted for sharing their reflections, and to Cheryl Hamilton of Auckland Regional Public Health Service for helpful suggestions and comments.

## **Introduction**

'Activities to increase the effectiveness and quality of public health service provision as well as the skills and understanding of the whole health sector, in particular District Health Boards and Primary Health Organisations in developing a population health approach' is one of the key objectives outlined in the Ministry of Health document 'Achieving Health for all People' (Ministry of Health, 2003).

In line with this objective the overall aim of this project was to develop champions for a public health and health promotion perspective amongst clinicians and senior management in PHOs. By increasing their understanding, it was hoped to increase support for health promotion and the wider public health approach in their PHOs, and ensure that health promotion workers and clinicians in PHOs do not operate within disengaged silos. The concept of the proposal encompasses the belief that clinicians can bring useful knowledge, skills and influence to many health promotion activities, especially when they work in conjunction with skilled health promotion advisors.

## **Proposal**

The project proposed the organisation of a series of training workshops for clinicians, PHO managers and health promotion advisors working together as teams to cover fundamental aspects of public health and health promotion thinking and planning. It was envisaged five workshops, 2 – 4 hours long each, be held, each focusing on a different stream of the Ottawa Charter, along with education about the place of the Treaty of Waitangi, other models of health promotion (eg Te Pae Mahutonga), the inequalities framework promoted by the Ministry of Health and the equity lens, wider determinants of health, and needs assessment. These workshops would be very much interactive, with initial teaching and then practice applying this to issues in participants' own communities. The workshops would be promoted to 'grassroots' clinicians as well as those in management/governance roles.

The workshops would be Stage Two of the project proposal, the consultation reported here constituting Stage One. It was planned to hold the workshops in early 2005 if consultation supported the proposal.

## **Aim of Stage One, Initial Consultation**

To determine the extent of buy-in to the underlying concept of the project from key stakeholders, identifying any barriers to participation, seeking possible solutions to overcome these barriers, and produce a report outlining the key elements considered essential for achieving an effective project outcome.

## **Methodology**

Face to face discussions, where at all possible, were held with representatives from all identified key stakeholders. Where face to face conversations were not possible telephone consultation was undertaken, along with communication by email.

Key stakeholders were identified as the 18 PHOs in the region, the three DHBs of the greater Auckland region, and the Ministry of Health Public Health Directorate at the Auckland office. In the PHOs consultation took place with health promotion personnel, or

those in the PHO with responsibility or oversight for health promotion planning and operations, along with those they identified within their PHO as appropriate to discuss the project with, given the intent of the project brief. Several other people identified from these discussions as potentially having an important contribution to the issues being raised were also contacted, and their feedback is incorporated with that of the PHOs.

This consultation aimed to identify any perceived issues arising regarding the intent of the project and sought suggestions for the priority areas for training should the project proceed to Stage Two. It was initially intended to try to further identify and consult with 'grassroots GPs and practice nurses' who might be interested in further health promotion training. However given the issues identified in initial consultations with PHOs, this was not pursued. A full list of those consulted is attached in Appendix One.

The views of individuals in these stakeholder groups have been necessarily been synthesised in the following summaries, which also attempt to portray the variety of views where this was present. It is important to remember that the thoughts reflected are those of people working at the coalface of PHO implementation in the Auckland region, and will subsequently need to be reviewed in light of experience and planning at a national level.

## **1. Response from consultation with PHO management, staff and clinicians**

While the PHOs across the wider Auckland region differ quite significantly in size, structure and 'culture' (in the broad sense of the term), there were consistent concerns expressed in the feedback obtained from most of the PHOs, which are outlined below. There were also other important related issues raised, which have been attached in Appendix Two.

Although the intent of Stage Two, to increase support for health promotion and the wider public health approach in PHOs, was acknowledged by most as necessary and important, the proposal for the workshops described above, as initially conceived, is not felt to be suitable at this point in time. This is principally because in considering potential barriers to the implementation of the proposed workshops, significant concerns related to wider issues about public health and health promotion in PHOs were raised, which most of those interviewed believe will impact on any education proposed, and therefore need to be addressed first. They believe that initiatives to clarify shared working definitions and expectations of PHOs in relation to their implementation of the primary care strategy, population health, health promotion and public health are needed with some urgency.

Thereafter, workforce development/education based on these clarified understandings would then be appropriate at a number of levels across the wider PHO setting, with management/governance level understanding, both in PHOs and DHBs, being a first priority.

## **Lack of clarity about what health promotion funding is for**

### **PHO's are struggling to understand 'health promotion' in their context**

It is perceived that at all levels of PHO operations there is a lot of goodwill and willingness to make the vision of the primary care strategy a reality. The strategy charges PHOs with not only providing personal health care services to their enrolled population, but also the need to take a population health approach, and consider the wider context of health and disease. However the lack of clarity about what exactly this population health approach is to encompass in a PHO, how this might look operationally (particularly in relation to the use of health promotion funding), and what the roles of the various players in this might be (including regional public health services and other health promotion providers), is of significant concern.

PHOs in the Auckland region perceive themselves to still be in an early consolidation phase, with management, staff and Boards still seeking to define their roles internally, and in relation to external organizations (eg NGOs). While it is understood that the Ministry of Health was purposely not prescriptive in outlining implementation plans for the Primary Care Strategy (including the particulars of health promotion planning) so that PHOs could grow out of, and respond to, local community needs, it is perceived that this lack of clarity has created situations of tension, where many in the wider PHO setting (both internally and externally) feel threatened at times. They believe that their functioning would be much enhanced by better clarity about the expected roles and functions of PHOs.

Where some of the PHOs have attempted to respond to their community's expressed concerns, they have been disillusioned to find that in fact priority concerns have been set for them by the DHB, and their plans based on local issues have not been accepted. The sense that they have raised community hopes and expectations by consulting broadly in the first instance has been difficult to address, whereas they perceive that if explicit and consistent guidelines had been given before consultation such consultation would have been undertaken differently. It was in fact suggested that if decisions have already been made about how the health promotion funding is to be spent, these outcomes could have been contracted for without consultation. However this process would not be seen to fulfill the vision of the Primary Care Strategy as those in PHOs understand it.

The importance of language was identified, with the various parties bringing their own understandings and definitions of public health, health promotion and population health approaches to the PHO table. Concern for the recognition of the unique place of Maori as tangata whenua within the wider view of population health was also raised, and an understanding of concepts such as whanaunatanga was seen to be important contribution. The desire to have definitions clarified at the Ministry of Health and DHB level was repeatedly articulated, but with a need for this clarity to reflect shared understanding of the interface of general practice, and public health/health promotion. In relation to the funding stream for health promotion, the importance of recognising the tensions created by trying to operationalise a policy of collaboration, in an environment set up for competition through the 1990s, has been underestimated in the opinion of many.

## **Health promotion versus population health**

While some have suggested there are potential benefits to relabelling current 'Health Promotion Funding' as 'PHO Population Health Funding', this raises concern from others. Those from the health promotion sector who have been employed in PHOs are aware that while the health promotion funding being given to PHOs is often relatively small in dollar terms compared to the amounts a PHO may receive for personal health care services, this funding is currently the only new Ministry funding for health promotion, and therefore strategically very important. As Daley has previously pointed out (Daley, 2003), historically health promoters had to distance themselves from health care services to gain traction for concepts about the need to address wider environmental and structural concerns. In needing to work more closely with health services providers again, there is now understandably a consequent fear of losing advocacy and community development gains, especially if the funding were not specifically allocated for health promotion.

### **Support for a wider view of health promotion?**

At present DHB / MoH acceptance of health promotion plans appears in the main, to those working in PHOs, only to acknowledge the provision of 'health promotion programmes' as valid health promotion. The reorientation of health services, promotion of healthy public policy and true community engagement, while being often quoted as work streams of the Ottawa Charter, do not appear to the PHOs to be given credence in what is acceptable in PHO health promotion plans.

<b>Integrated or separate?</b>
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PHO Boards set the strategic direction for their PHOs' activities, supporting and guiding management, so the importance of their better understanding Ministry intentions and definitions, and their own roles was emphasised, along with support for them to operationalise their strategic priorities. The existing strength of some Boards, particularly those operating on Maori or Pacific cultural models based on collective action, which inherently work on public health principles although not necessarily identified as such, was recognised.

The fact that the new health promotion funding has been channeled through PHOs would suggest that it might be used in different and complementary ways to traditional health promotion contracts funded directly from the Ministry. However without shared understanding of the broader concepts of health promotion at PHO Board and Management level, and among DHB staff, exploration of what health promotion might be in the PHO setting is likely to be stifled.

From the general practice perspective, while it is acknowledged that primary health care is different from primary medical care, PHOs have been created on the revenue streams, and databases of general practice, and are seen to present a unique opportunity to integrate general practice care with wider approaches. However it is perceived that in most instances it is appropriate that practice level activity continue to be largely focused on individual level care, while there is another distinct and evolving 'PHO level' of activity, which addresses population approaches.

## **Acknowledging the general practice view**

Building on the strengths of current services and world views is seen to be an important strategy. It is perceived that helping providers understand how health promotion approaches add value to the work they are already doing, and showing them the evidence for this, has more potential for engaging them in the processes than theory driven models.

For instance the work of US public health physician Barbara Starfield in defining and highlighting the importance of primary care is well known in general practice but rarely mentioned in public health circles. Similarly, clinicians would suggest evidence regarding the potential success of interventions in general practice (eg brief interventions motivating people to give up smoking) needs to be considered alongside the broader determinants of health seen to be important in the public health view. Recognising the skills acquired by general practitioners as small business owners who have learned to deal with conflicting priorities, human resource issues, etc in the day to day operations of their practices, again, can be perceived of as strengths to be built on in encouraging them to consider wider community issues.

It was suggested that in fact the processes of public health/health promotion, and general practice can be seen as quite similar (eg assessing need, considering priorities, planning intervention, reviewing progress) but operate in different contexts, using different tools. Building on these similarities, rather than continuing to highlight differences, was seen to be a helpful strategy in progressing the vision of the Primary Care Strategy. The notion of settings based health promotion raises the potential for general practice to be considered a 'setting', which has particular strengths that can be utilised for attaining health promotion goals.

Those from a general practice background acknowledge there are many with high needs who do not present to traditional general practice, with whom the PHO needs to engage to find strategies which do meet their needs. Community health workers are seen by some as potential vital links in this engagement. However population health approaches are also seen to have the potential to enhance the work of general practice teams with those who do present, with whom they have preexisting trusting relationships. From the general practice perspective these population approaches include implementing systems to better co-ordinate chronic disease and referred services management, along with more systematic approaches to screening and lifestyle interventions (ie individual health managed at a population level to achieve population outcomes). Such a definition is complementary to those focused on wider, more intersectoral approaches, rather than exclusive.

However, currently in the general practice setting, health promotion is likely to be perceived of primarily in terms of health education, and without understanding how this is only a part of the bigger picture of health promotion, energy and funding may remain focused at this level, with potential gains not eventuating.

## **Funding for integration**

In many organisations time is prioritised according to funding, and if there is no funding allocated to support collaboration, the prioritised time needed to build relationships will not be considered a priority. Even in PHOs where the partnership structure involves

preexisting health promotion organisations, prioritised time is seen to be needed to integrate and build relationships between these organizations and clinical services, thus contributing to a reorientation of these health services. Similarly workforce development aimed at increasing understanding of health promotion principles and strategies across PHO staff is seen to be part of the reorientation of services.

The recognition that health promotion personnel often have the knowledge of, and relationships with, other providers to contribute to planning approaches that increase collaboration and reduce duplication of services in the community was not felt, in some instances, to be adequately recognised by others in the PHO setting. Similarly the belief that health promotion workers can and need to be advocates in PHOs for community, and Treaty perspectives was expressed.

### **Capacity**

At present a barrier to engaging with this wider understanding is the volume of new initiatives being expected of general practice teams. Providers are overwhelmed with the implementation of CarePlus, and disease management initiatives, along with SIA projects, and now also the MeNZB project; and much of the new workload falls to practice nurses. PHO Boards feel a great sense of responsibility to their communities to use their health promotion funding strategically, but many are hampered from doing so at present because of lack of capacity to do so<sup>1</sup>.

### **Learning through evaluation**

Improved understanding of the appropriate evaluation and reporting of health promotion initiatives was identified as an area of priority, but also physical and funding support (particularly for smaller PHOs) to undertake this properly. Collaborative district-wide health promotion planning between PHOs was seen by some to provide a potential contribution towards this. This process was seen to need to be well supported by DHBs, with continued funding of health promotion and public health positions supporting PHOs, and potentially with active DHB input to engage smaller PHOs in the process..

The need to get started, and take some risks was articulated, but with the proviso that there is adequate documentation and evaluation for shared learning from both successes and failures, and appropriate accountability.

### **Application of the 'broad' public health view**

It was suggested that in addition to these concerns which largely centre around the place and spending of health promotion funding, application of the public health equity lens, and emphasis on the need for intersectoral collaboration could be enhanced by increased understanding of these perspectives at levels of PHO Boards and management, and DHB funding and planning staff. Dialogue about strategies to address the tension of trying to serve the "community" in district wide collaborative planning when funding is allocated for an enrolled population, to whom a PHO Board may feel first responsibility, would be helpful (this is particularly so when health promotion funding is

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<sup>1</sup> In some instances where there has been funding to employ staff specifically to implement projects, there has been little response to advertising

small in dollar terms, and the PHO population is quite different from that in the rest of a DHB).

## **2. Response from consultation with DHB representatives**

As with the PHO representatives, the current proposal for the Stage Two workshops as described is not felt to be suitable at this point in time because of the need for clarity to be established first, and other related education initiatives needing priority.

In clarifying understanding, it is suggested that it may be more helpful to think about the population health concept because it can be seen to encompass traditional public health, personal health and health promotion. It is potentially less threatening to define a new term, rather than redefine old ones and have people feel like someone is 'stealing their patch'.

There was a consistent message from DHB staff consulted that there needs to be joint dialogue to develop an explicit shared understanding by the Ministry, DHBs, and PHO management and governance about

- what population health actually is in primary care for PHOs
- what level we are expecting these population health approaches to be operationalised (grassroots providers, or at the PHO level), and how the tension between provision for geographical community versus enrolled populations is to be managed
- what outcomes are expected
- how these outcomes are to be evaluated, including consideration of effectiveness and quality
- how this PHO activity fits together with that of regional public health services, and other health promotion providers<sup>2</sup>.

Other measures seen to be important before initiating significant 'grassroots' training in PHOs included initiatives to promote better understanding of population health, along with traditional public health and health promotion principles, by DHB funding and planning staff to enhance their role, a common understanding about effective community partnerships, and consistent, district wide principles to apply to the assessment of health promotion plans to assist in the processing of these (acknowledging again the tension with the need for local responsiveness).

It is perceived that consideration needs to be given to the expected funding streams to be used for PHO level activity, related to the current review of the management fee, particularly to address the resource and technical support needs of smaller PHOs. A related review of the health promotion funding formula would be important if PHOs are to accomplish significant population outcomes, especially smaller PHOs with high needs populations (there is concern that current funding arrangements may exacerbate inequalities). Concern was also expressed that the indicators being developed for PHO

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<sup>2</sup> Interestingly this somewhat mirrors a UK finding related to the advancement of Primary Care Trusts cited in the recent PHAC discussion paper, Emerging Issues for Public Health in New Zealand: 'while overall commitment to inter-sectoral work in public health is strong, there is little clarity as to how different players should be interacting with each other' (Public Health Advisory Committee, 2004).

activity need to be designed to actually measure PHO level activity rather than provider level activity.

Once expectations are clearly delineated, it would be necessary for training to be initiated for all those immediately effected, including any DHB staff who deal with PHOs not involved with initial discussions, PHO Boards / governance, and PHO management. Subsequently, education for GP teams and other providers to understand how they contribute to the bigger picture, what population health and health promotion might mean for them and how this might involve community, could be developed.

There is seen to be an important window of opportunity to address these issues, with meetings to develop shared understandings, and subsequent education initiatives to disseminate these, needing to take place in early 2005, so that there is a clear pathway in place for the next planning and funding cycle. The initial dialogue would need to be followed up with ongoing commitment to exploring issues together as the "PHO journey" continues to unfold.

### **3. Response from consultation with Ministry of Health Public Health Directorate, Auckland office**

The Ministry's public health directorate in the Auckland office expressed the need for training at the level of PHO management and governance as a key priority. Their perception is that attempting to develop champions among grassroots clinicians at this point in time may be counterproductive until understanding and processes are established at a management level. They could foresee a 'champion's' ideas being frustrated by decisions made at management level based on lack of understanding of the public health/health promotion perspective. It is also anticipated that, given the current heavy demands on clinicians in their practices, those in management are more likely to be involved in public health / health promotion activity in the PHOs at present.

The content of the training for the management/governance level is believed to be needed to be focused at a level appropriate for the day to day demands of those management positions, and address broader public health approaches rather than focusing primarily on health promotion (eg epidemiological evidence base, the equity lens). The suitability of currently funded options (eg SHORE training) could be explored.

It was anticipated that funding for the attendance of clinicians at the proposed workshops might be seen as a barrier to participation, and since the brief for consultation included addressing potential barriers, the suggestion of using PHO Health Promotion Funding for such payment was explored. While such decisions were seen to rest with DHBs, and targeting PHO management initially was thought to probably largely alleviate this issue, PHO Health Promotion Funding was not considered a suitable source to pay clinicians to attend any future training envisaged. If grassroots clinician training is proposed, other solutions for this issue will need to be considered.

## A Suggested Way Forward

Synthesising the views outlined above, the following is a suggested way forward to address the issues raised. A strengths-based approach, building on the assets offered by all those involved in the sector is seen to be fundamental to progress.

1. A meeting be held between Ministry representatives from the public health and primary care teams, DHB staff with responsibility for working with PHOs, and representatives from the PHOs, to come to an agreement on definitions and expectations of PHOs in relation to the primary care strategy, population health, health promotion and public health<sup>3</sup>. Suggested definitions have been made in previous Ministry publications (eg Public Health in a Primary Health Care Setting), but it is the practical implementation of these, with subsequent funding implications, which needs increased and shared clarity. It is recognised that such a meeting could have an unwieldy large number of people attending, but the importance of all parties hearing the same understandings articulated was seen to be important<sup>4</sup>.
2. This meeting needs to be followed with the establishment of clear, consistent guidelines for what is acceptable use of health promotion funding in PHOs, along with consistent, timely procedures across all DHBs for the sign-off process for health promotion plans. Again these guidelines need to be established in collaboration with those actually working in PHOs, generating shared ownership of the process. Generation of practical tools to assist PHO management is considered important in this process (eg templates that do not require repetition of PHO strategic plans etc when those are already lodged with the DHB, and commitment to any changes to these templates being made in consultation and with appropriate notice).
3. Once these expectations are clearly delineated, training be initiated for all those immediately effected so that there really is shared understanding
  - e. DHB staff not involved with initial discussions as per 1 above. (eg funding and planning staff)
  - f. PHO Boards / CEOs, emphasising related strategic decision making
  - g. PHO management, emphasising practical operational issues.
  - h. In PHOs where those responsible for health promotion planning and oversight have not had formal health promotion training, more intensive training may be appropriateIn addition, shared understanding initiatives need to include those working in Regional Public Health Services, to support their engagement with PHOs and encourage strong linkages between providers.
4. Once those involved at these levels are then confident of their roles and expectations, it is suggested that training for clinical providers could begin by way

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<sup>3</sup> It is also important to note that while this report identifies such a request from PHOs in the wider Auckland region, conversations with those in other areas have identified similar issues of concern.

<sup>4</sup> A similar meeting has been held with primary care representatives from the Ministry regarding CarePlus, with some 60 – 70 people present, and appeared to have a satisfactory outcome

of a CPE session provided in the setting of PHO regular educational meetings (eg cell groups). The content for these sessions was identified to need to

- start from primary care perspectives and activities
- be pragmatic and based around a tangible issue (GP teams are seen to not respond to “airey fairey principles”)
- look at the continuum of possible related health promotion / population health activities
- encourage GP teams to understand how they contribute to the bigger picture/ what population health and health promotion might mean for them and how this might involve community in a wider context, how the structural flow of their practice might need reconsidering to meet such challenges

Where regular meetings are not available for use, it will be important to ‘buy the time’ of clinical teams; frequently salaried professionals are seen to forget that when a GP or nurse attend frequent evening meetings, they do not have the facility to take time off during the day to compensate for their time given.

In determining appropriate provision of such training, there were perceived advantages of the training at the Board/management levels being provided by an independent source, including providing some distance from day to day implementation issues, and the possibility of employing presenters seen to be credible to the audience in question. Utilising a team, including a public health physician with a general practice background, along with an experienced health promoter is suggested as a useful combination.

For training of clinical providers within PHOs, some would prefer the availability of an independent presenter, while others felt a ‘train the trainer’ mechanism using PHO staff was likely to be a useful strategy, as each would know their own providers, and how to engage them. An outline of a generic CPE session, which could then be modified by each PHO to suit its own setting would be considered helpful by some.

Training would need to be offered in the evening for Boards, and clinical providers, and to be coordinated with other meetings happening in the sector to avoid clashes that would potentially reduce impact.

In light of the feedback obtained, and the suggested way forward, the following recommendations are made to progress the intent of this project, to increase support for health promotion and the wider public health approach in PHOs:

- 1. That although the intent of the project is acknowledged as necessary and important, this project does not proceed to Stage Two as initially proposed, at this point in time.**
  
- 5. That the project consultant, and the project sponsor from Auckland Regional Public Health Services meet with Ministry representatives to discuss further the suggested way forward outlined in this report. It is suggested that the discussion to clarify shared working definitions and expectations of PHO activity fundamental to further education initiatives will need to also consider national involvement in this process, the recommendations of the SHORE report (Penney et al., 2003), and the potential need to consult with other organisations (eg PHA, College of GPs)**
  
- 6. That, giving consideration to the outcomes of the above meeting, Auckland Regional Public Health Service develops and implements an action plan to progress the suggested way forward outlined in this report.**

## References

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<b>Appendix One : Those consulted in Stage One</b>
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Barbara Stevens	- Auckland PHO
Malia Tuai	- AuckPac PHO
Nicola Young	- Procure Networks
Guy Naden	- Tamaki Healthcare
Allison Dolphin	- Tikapa Moana PHO
Viliami Tiseli	- Tongan Health Society
Lesley Prest	- East Health
Michael Lamont	- Mangere Community Health Trust
Colleen Turnbull	- People's Health Trust
Aumea Herman	- TaPasefika
Naita Puniani	- TaPasefika
Louise McCarthy	- Total Healthcare Otara
Rakesh Patel	- Total Healthcare Otara
Leah Broughton	- Te Kupenga o Hoturoa
Mel Mahoney	- Coast to Coast
Nancy Malloy	- Coast to Coast
Lannes Johnson	- HealthWEST
Lyvia Marsden	- North Harbour PHO
Jill Leitao	- North Harbour PHO
Ann Sorley	- North Harbour PHO
Shane Scahill	- North Harbour PHO
Edith McNeill	- Waiora Healthcare Trust
Nikki Turner	- Waiora Healthcare Trust
Kathrine Clarke	- Hapai Te Hauora Tapui
Pat Neuwalt	- PhD Student (Development of community participation in PHOs)
Debbie Petersen	- Waikato PHO
Ngaire Rae	- Manaia PHO
Tom Robinson	- Public Health Physician / GP
Paul Bohmer	- Ministry of Health
Shayne Nahu	- Ministry of Health
Candace Bagnall	- Ministry of Health
Maggie McGregor	- Ministry of Health
Warren Lindberg	- NDSA
Utulei Antipas	- ADHB
Danny Wu	- CMDHB
Andrew Lindsay	- WDHB

## Appendix Two: Other related concerns/ideas expressed

1. Increased sharing of ideas of what is being done in other PHOs, both within this region and across the country, would reduce everyone reinventing wheels, while allowing for modification for different communities. Here the consistency of DHB approach becomes particularly important, as at present there would be instances of projects accepted in one DHB being shared, only to be turned down by another DHB.

Sharing of ideas would also need the Ministry to address the issue of Intellectual Property rights being attached to ideas generated with, what many would see, as ultimately public money.

2. While joint appointments of public health specialists between DHB and PHOs have been a useful strategy in some instances, and deemed worthy of consideration for more widespread application, it is recognised that not all public health training has a strong focus on health promotion

3. In the absence of national PHO workforce development initiatives, some PHOs are organizing their own workforce development (eg HealthWest's Primary Care Assistants role and Family Fitness Intervention Roles). Beyond the Auckland region, Debbie Petersen, health promotion advisor to the Waikato PHO, has focused on developing health promotion capacity, organising training for those working in or relating to health promotion planning and programmes in their organisation. This was very well received, with more people wishing to attend than numbers allowed.

4. Some in Pacific PHOs identified the need for an attractive career pathway for younger community health workers, given that the Pacific population is relatively young but most community workers are older. Public presentation and working with evidence base are seen to be important skills to foster.

5. The opportunity to consider further health promotion training at a University level would be welcomed by some, if there were financial support and the content offered appeared relevant (eg from an appropriate cultural base for the population being worked with) and practical.