

health

Community Health Integrated Health Promotion Program

PLANNING GUIDELINES 2013-17

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Introduction

The purpose of these guidelines is to outline the planning requirements to be met by agencies funded through the Community Health Integrated Health Promotion (IHP) Program.

In accordance with the *Public Health and Wellbeing Act* and the *Victorian Public Health and Wellbeing Plan 2011-2015 (State Plan)*, the IHP planning cycle is now aligned with the Municipal Public Health and Wellbeing Plan (MPHWP) planning cycle from 2013 to 2017. The State Plan represents the prevention system's contribution to the Victorian Health Plan 2022. MPHWP's, must under the Act, have regard to the State Plan. The purpose of the alignment of IHP planning is to ensure that the IHP investment in the prevention system contributes to the achievement of the State Plan through supporting MPHWP's and other contributing planning processes to the health and wellbeing of local communities.

Separate but complementary guidelines are to be provided for Women's Health Services and Primary Care Partnerships (PCP's).

It is expected that agencies will work with local partners, to develop a plan intended to cover the entire four-year period, with any revisions and amendments submitted to the department on an annual basis.

Key requirements and timelines for completion 2013-17

Requirement	Due date
Confirm planned priority areas and objectives with your regional office	31 August 2013
Final 2013-17 IHP Plan – agency or catchment plan, including evaluation planning and budget	31 October 2013
Annual update to IHP Plan – i.e. amendments to interventions, updates to evaluation planning	Annually by 31 October (i.e. October 2014, 2015, 2016)
Report against evaluation plan for each objective¹	Annually by 31 August (i.e. August 2014, 2015, 2016 and 2017)
Budget acquittal	Annually by 31 August

Role of regional offices and requirement to submit a draft IHP plan

In addition to the requirements outlined in these guidelines, agencies must ensure that they adhere to local planning requirements as set out by regional department of health offices (e.g. in relation to priority setting).

Partnerships and catchment planning

Partnerships are a crucial aspect of the IHP Program and it is expected that agencies will capitalise on existing resources by working with relevant organisations. Agencies are encouraged to pool resources and effort, where appropriate, to maximise impact. For example, a number of agencies are already pooling resources through Healthy Together Communities or as part of catchment planning processes.

The alignment and contribution of the IHP planning to local government MPHWP's provides an even greater opportunity to strengthen collaborative effort in terms of planning, implementation and promoting the health and well-being of local communities. Information on the requirements of local government and links to relevant data and resources are outlined in: [Guide to Municipal Public Health and Wellbeing Planning](#).

¹ Reporting guidance will be provided as a separate but complementary document to the planning guidelines.

The department will continue to accept catchment (i.e. PCP's) plans in lieu of individual agency plans as long as roles and responsibilities are made explicit in the catchment plan (i.e. what aspects of MPHWP's within the catchment is your agency specifically contributing to?) and all planning components are addressed. Each agency will still be required to submit a separate IHP budget for accountability purposes).

In cases where only some planning elements overlap with catchment planning, agencies will need to submit their own IHP plan but may refer to other plans where relevant. For example, agencies can refer to local government MPHWP's plans for details of joint data collection, priority setting processes, selection of interventions, with other PCP partners etc. Again, roles and responsibilities must be clear.

Healthy Together Communities (HTC)

Agencies contributing 100 per cent of their IHP funding to a HTC are not required to submit an IHP plan or report against this work (instead please refer to the relevant HTC plans and reports).

If only part of an agency's IHP funding is going towards a HTC, an IHP plan is still required to cover the IHP work that sits outside of the HTC.

In either case, agencies are required to provide a budget overview and annual acquittal to their regional office to ensure accountability (see below). Please discuss these expectations with your regional office.

Budget overview

An annual budget overview and acquittal is a new requirement for 2013-17 (see template at Appendix D). Please note that plans will not be accepted by the department unless a budget overview is provided.

IHP Continuous Quality Improvement Tool

Agencies are encouraged to complete the IHP Continuous Quality Improvement Tool as part of organisational or catchment strategic planning, but this is no longer a formal requirement and does not need to be submitted to the department.

Resources to support IHP planning and evaluation

At the end of this document are a number of appendices to support IHP planning:

Appendix A – Program logic template

Appendix B – Integrated health promotion planning summary template

Appendix C – Selection criteria for IHP interventions

Appendix D – Budget templates

An updated ***IHP Evaluation Planning Framework*** is also provided at **Attachment 1** to support evaluation planning.

A list of useful resources is provided on page 10.

If you have any questions relating to these guidelines or any other aspect of IHP planning and reporting, please contact your regional department of health office.

Planning component	Timeline		
<p>1. Vision setting</p> <p>The vision statement should articulate where you want to be in respect to your Integrated Health Promotion response within a defined period of time.</p> <p>The vision articulated should reflect health promotion principles² and ensure that all key stakeholders are involved in developing this vision.</p>	<p><i>Every four years</i></p>		
<p>2. Priority setting and problem definition</p> <p>It is essential to identify a limited number of priority issues (e.g. 1-3), proportionate to the level of funding received and with regard to the regional planning context. It is better to focus on fewer well funded interventions than to tackle many underfunded interventions that may result in unclear outcomes.</p> <p>In the context of finite resources and competing pressures, agencies must be able to justify their selection of priorities. A rationale for selection should be provided under each priority area, which then links to the selection of goals, objectives and interventions.</p> <p>As part of the priority setting and problem definition process, the following areas should be considered.</p> <p>(a) Key policy documents</p> <p>It is expected that the priority setting process will be informed by the priority health issues and settings identified in the <i>Victorian Public Health and Wellbeing Plan 2011-2015</i>.</p> <table border="0" data-bbox="199 1205 1316 1529"> <tr> <td data-bbox="199 1205 774 1529"> <p><u>Health issues</u></p> <ul style="list-style-type: none"> Increasing healthy eating Increasing physical activity Controlling tobacco use Improving oral health Reducing misuse of alcohol and drugs Promoting sexual and reproductive health Promoting mental health Preventing injury Preventing skin cancer </td> <td data-bbox="805 1205 1316 1529"> <p><u>Settings</u></p> <ul style="list-style-type: none"> Local communities and environments Workplaces Health services Early childhood and education settings </td> </tr> </table> <p>Other relevant policies and strategies may include: Koolin Balit, Reducing the Alcohol and Drug Toll, Healthy Together Victoria, Victorian Action Plan for Oral Health Promotion, Action Plan to Address Violence Against Women and Children. Please see full list of resources on page 10.</p> <p><i>Agencies should also refer to relevant regional office planning guidance in the development of priorities.</i></p> <p>(b) Data and other evidence</p> <p>The ability to effectively identify relevant priority issues and target population groups relies on accurate and timely data and information about the local health and social needs. A range of resources are available to inform this process, many of</p>	<p><u>Health issues</u></p> <ul style="list-style-type: none"> Increasing healthy eating Increasing physical activity Controlling tobacco use Improving oral health Reducing misuse of alcohol and drugs Promoting sexual and reproductive health Promoting mental health Preventing injury Preventing skin cancer 	<p><u>Settings</u></p> <ul style="list-style-type: none"> Local communities and environments Workplaces Health services Early childhood and education settings 	<p><i>Every four years</i></p>
<p><u>Health issues</u></p> <ul style="list-style-type: none"> Increasing healthy eating Increasing physical activity Controlling tobacco use Improving oral health Reducing misuse of alcohol and drugs Promoting sexual and reproductive health Promoting mental health Preventing injury Preventing skin cancer 	<p><u>Settings</u></p> <ul style="list-style-type: none"> Local communities and environments Workplaces Health services Early childhood and education settings 		

² Refer to: http://www.health.vic.gov.au/pcps/downloads/publications/ihprpt_jul05.pdf and [http://docs.health.vic.gov.au/docs/doc/8532A3E8DAD73048CA2578FE000571F5/\\$FILE/vic-public-health-wellbeing-plan.pdf](http://docs.health.vic.gov.au/docs/doc/8532A3E8DAD73048CA2578FE000571F5/$FILE/vic-public-health-wellbeing-plan.pdf) (p.13)

which are detailed in the [Guide to Municipal Public Health and Wellbeing Planning](#) (refer to part 3).

Evidence should also be gathered from local agencies and partners who may have information about local need that is not formally published.

(c) Community/stakeholder consultation

Listening to what local people believe could improve their community and to their ideas about changes they want to achieve is an important part of the process of designing effective health promotion interventions.

Similarly, it is necessary to identify and consult with relevant stakeholders to determine what is already happening, what needs to be done, and who is best placed to undertake the work (i.e. a situational analysis). Stakeholders might include PCP's, Medicare Locals, health and welfare services, local government and community organisations.

(d) Alignment with local government

The alignment of planning cycles for IHP funded agencies and local government from 2013-17 supports strengthened integrated planning, intervention and evaluation with local government and contribution to MPHWP's. PCP's have an important role in assisting in the coordination of this collaborative planning process.

(e) Sphere of influence and capacity issues

It is important to consider the amenability to change at the local level. What can be influenced? Does the agency/partnership have the capacity to make a difference? Particular attention should be given to possible gaps in local IHP planning by mapping the local prevention system and identifying the fit with contributions to community health and wellbeing by other partners in the local prevention system..

A note on capacity building

Capacity building for IHP enhances the potential of the system to prolong and multiply health effects.³ Capacity building should not be included as a separate priority area, but rather incorporated into planning for other priority areas as a means of achieving effective and sustainable health program initiatives. Capacity building is a means to achieving an outcome, rather than a goal of its own.

3. Solution generation

Solution generation combines knowledge from an array of sources with innovative thinking to produce interventions that are effective and sustainable.

The key components to be completed in this section are:

3.1 Program logic

The program logic is a high level planning tool that succinctly demonstrates the logical reasoning connecting the program activities to the ultimate program goals. There should be a clear link between the activities/strategies and the expected outputs and impacts, together with a consideration of the contextual or uncontrolled influences.

A program logic template is provided at **Appendix A**. The key components are briefly described on the below.

Completed once every four years (with amendments made annually if required)

³ Integrated Health Promotion Resources Kit. Melbourne: DHS. Department of Human Services (2004).

Program Logic Overview

Inputs	Activities	Outputs	Impacts	Outcomes
Resources (inc. budget)	What you will do	Program or strategy deliverables immediately after intervention Linked to process indicators <i>E.g.</i> Reach	Linked to objectives/ community impact indicators <i>E.g.</i> Change in knowledge, skills, attitudes (1-18 months post intervention) Change in environment Change in behaviours (12 months-3 years post intervention)	Linked to goals <i>E.g.</i> Change in population health status and wellbeing 3-5 years after intervention

3.2 Planning summary

Details of your priorities, goals, objectives, interventions, targets groups and roles and responsibilities (including partnerships) are to be provided to the department.

The *IHP Planning Summary Template* at **Appendix B** has been developed to capture each of these components (along with the evaluation planning requirements outlined in the next section).

A brief description of each component is outlined below.

(a) *Goals*

Goals should be established for four years or longer. Outcomes are not expected to be measured or reported to the department, but help to frame the overall, longer-term focus of the health promotion activity undertaken in a catchment. (see <http://www.health.vic.gov.au/healthstatus/survey/vphs.htm>)

Planned across the four years.

(b) *Objectives*

Objectives should be specific, measurable, achievable, realistic and timely (SMART). They are more operational than goals and, where possible, should be developed for the duration of the health promotion plan. In some cases, the annual review process may indicate that revision of objectives is required.

Objectives may need to be adjusted over time.

A budget is required at the objective level (refer to item 5 – budget overview).

(c) *Interventions*

A range of evidence-informed interventions should be considered in consultation with identified partners that takes account of implementation effectiveness contribution to local impact. If there is limited evidence available agencies should be conscious of the need to undertake evaluation in order to demonstrate the impact of the intervention/s and contribute to the evidence base. Please refer to the intervention selection criteria at **Appendix C** to assist in identifying evidence-based interventions.

Interventions should be reviewed and updated annually to ensure effectiveness and relevance.

The description of interventions provided to the department should be succinct (i.e.

details of every task associated with the intervention are not required) but should clearly articulate what will be undertaken in a way that an external reader can understand.

Examples:

- Complete the Victorian Healthy Food Basket Survey and location of essential food stores in 'x' to measure the affordability and availability of the local food supply and use to guide change.
- Establish and facilitate a weekly Community Kitchen in 'x' for men, covering budgeting, shopping, food preparation and cooking skills.
- Run the Girls Talk Guys Talk 14-month program, with Year 9 students in 'x' and 'y' schools. Girls Talk Guys Talk extends the World Health Organization whole of school approach by combining it with a year 9 sexuality education program and the VicHealth participation for health framework. The program supports young people to gain the knowledge, skills and resources they need for healthy relationships and sexual choices.

As part of an annual review of the health promotion plan, consider whether any amendments are required to ensure that the interventions delivered are relevant and effective.

(d) Population groups and settings

As part of the broader priority setting and problem definition process, the main 'at risk' population groups and/or relevant settings for action will have been identified. Please specify which population groups and/or settings are to be prioritised in the IHP planning summary (this information will likely appear against objectives and in your intervention descriptions).

(e) Timelines and responsibilities

Working collaboratively with partners to implement interventions and achieve shared objectives is an important element of integrated health promotion activity. As mentioned previously, in the case of joint activity it is important that roles and responsibilities are defined – e.g. is there a lead agency? It is also important that the timelines for implementation and evaluation are clear. This may need to be adjusted as part of the annual review process.

4. Evaluation planning

Completing a program logic for your objectives will identify what is to be achieved and how this connects with the chosen interventions.

The purpose of evaluation planning is to provide a thorough description of how the achievement of (or progress towards) objectives will be determined.

The key components that need to be addressed are covered in the *Integrated Health Promotion Planning Summary Template* at **Appendix B**. The *Integrated Health Promotion Evaluation Planning Framework* at **Attachment 1** should also be used to guide the completion of thorough evaluation planning.

2013-17 evaluation planning expectations

Process and impact indicators should be developed for the entire health promotion plan, although these may be amended annually if required (for example as the work progresses or further data comes to light). Where appropriate, these should be aligned with indicators in MPHWP's.

Evaluation should be appropriate and realistic, with a focus on developing indicators that can demonstrate progress on an annual basis in addition to measuring impact over the duration of the health promotion plan (i.e. four years). In most cases, particularly where there is an existing evidence-base for an intervention, agencies should focus on the shorter-term, proximal impacts of interventions.

Note that the 'timelines and responsibilities' criteria of the IHP planning summary

Planned across the four years but revised/updated annually

template allows agencies to clarify when different levels of evaluation are planned for completion and to prioritise evaluation resources over the four years. For example, in year one there may be interventions that are not fully developed (i.e. are at a needs assessment/developmental phase) meaning that impact evaluation is not appropriate or possible.

Agencies are encouraged to pool evaluation resources, for example through PCP's or local government, and in some cases may choose to allocate evaluation resources to engage external evaluation expertise (particularly where a more complex study design is required).

Please note that agencies are expected to use *Integrated Health Promotion Planning Summary Template* unless a variation is approved by your regional office prior to submitting your plan (eg where agencies are using QIPPS).

5. Budget overview

Agencies are required to provide an overall IHP funding breakdown and a budget per objective using the templates at **Appendix D**.

Annually

Useful resources

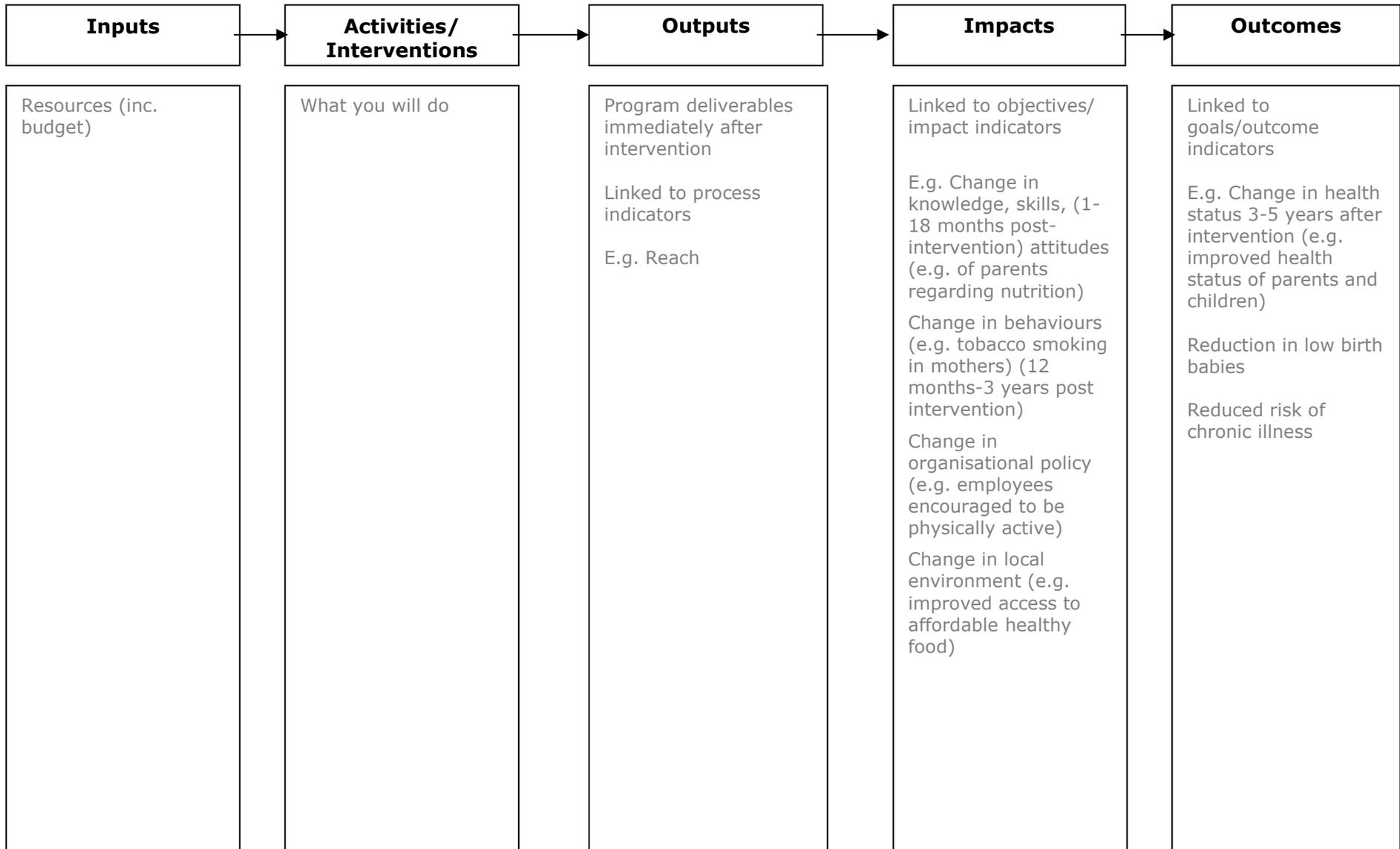
Planning and evaluation resources

1. [2012 Local Government Area Profiles](#)
2. [Evidence and Evaluation Tools](#)
3. [Guide to Municipal Public Health and Wellbeing Planning 2013-2017](#) (refer to part 3 for additional planning resources)
4. [Health Promotion in Gippsland - resources](#)
5. [Integrated Health Promotion Continuous Quality Improvement Tool](#) (link to be updated shortly)
6. [Integrated Health Promotion Resource Kit](#)
7. [Population Health Approaches to Planning - Victorian Healthcare Association](#)
8. [Program Logic Overview](#)
9. [The Centre of Excellence in Intervention and Prevention Science - Resources](#)
10. [The Language of Prevention, National Public Health Partnership](#)
11. [Victorian Population Health Survey](#)
12. [Victorian Public Health and Wellbeing Plan 2011-2015](#)

Priority/setting/population group specific resources

13. [Action Plan to Address Violence Against Women and Children 2012-2015](#)
14. [Healthy Together Victoria](#)
15. [Koolin Balit - Victorian Government strategic directions for Aboriginal health 2012-2022](#)
16. [Mental Health Promotion – Guide for Policy Makers](#) and [Victorian Mental Health Promotion Website](#)
17. [Reducing the Alcohol and Drug Toll 2013-2017](#)
18. [Skin Cancer Prevention Framework 2013-2017](#)
19. [The Co-ops Collaboration of Community-Based Obesity Prevention Sites - Links](#)
20. [Victorian Action Plan for Oral Health Promotion 2013-2017](#)
21. [Victorian Falls Prevention Webpage](#)
22. [Victorian Healthy Eating Enterprise](#)
23. [Victorian Injury Surveillance Unit](#)
24. [Victorian Network of Smokefree Healthcare Services](#)

Appendix A Program logic template



Appendix B Integrated Health Promotion Planning Summary Template

Priority Area			
Goal			
Target population group/s			
Budget and resources (include evaluation budget)			
Key evaluation question/s			
Objective 1	Impact indicators	Evaluation methods/tools	Timelines and responsibilities (include partners as relevant)
Interventions/Strategies	Process indicators	Evaluation methods/tools	Timelines and responsibilities (include partners as relevant)
1.1			
1.2			
1.3			
Evaluation design			
Data analysis and interpretation			
Evaluation dissemination			

Notes:

1. Agencies should use this template unless a variation is approved by your regional office. If using QIPPS you may wish to use the QIPPS planning template and then add additional information around evaluation design, dissemination etc as needed.
2. In some cases (eg in the case of a larger initiative covering multiple objectives) it may be appropriate to provide overarching information on evaluation questions/design/dissemination by priority area. Seek advice from your regional office if you are unsure.

Appendix C Selection criteria for IHP interventions

The following table is based on the Healthy Together Victoria Healthy Living Programs and Strategies Selection Criteria.

Agencies should use this to guide the selection of interventions, but are not required to submit the completed table to the department.

Selection criteria for IHP interventions	
<p>1. What are the objectives of the intervention?</p> <ul style="list-style-type: none"> • Which priorities from the Victorian Public Health and Wellbeing Plan 2012-15 does the intervention address? 	
<p>2. Describe program or strategy target groups or settings for change:</p> <ul style="list-style-type: none"> • whole of population • population group i.e. by age, gender, culture, SES or other criteria • service change i.e. food access, other • statewide/regional/local environmental change • statewide/regional/local policy, regulation • cultural change 	
<p>3. What methodologies are used:</p> <ul style="list-style-type: none"> • information or education increasing self-efficacy and health literacy • practical skills development • participation opportunities, contributing for example to increased healthy eating, physical activity and/or healthy weight • strengthen community action / create supportive environments • other, define 	
Evidence of effectiveness	
<p>4. Best available programs and strategies</p> <p>Evidence of program effectiveness should take into account:</p> <ol style="list-style-type: none"> a. the number of studies / sources of information b. research design of studies / sources of information (which should be the highest level appropriate) c. quality of studies / sources of information d. consistency of findings <p>Provide (or link to) a summary of available evidence (e.g. systematic reviews) or specify if no evidence is available and you wish to build evidence.</p>	

<p>5. Evidence of adequate participation and sustained benefit?</p> <p>The evidence should be relevant to the target population groups, targeted services etc.</p> <p>This could include evidence from the published literature (e.g. systematic reviews) and/or information from the delivery from previous delivery of the same or similar programs or strategies.</p> <p>Specify if no evidence is available and you wish to build evidence.</p>	
<p>Responsiveness to community need</p>	
<p>6. The program is inclusive of identified priority population groups.</p>	
<p>7. The program can be adapted to local needs and conditions.</p>	
<p>8. Any participation cost or charge (if required) are reasonable for the service provided. Low income families / communities are not disadvantaged by cost.</p>	
<p>9. Relevant resources, tools and training (as required) are available.</p>	
<p>10. Human rights and ethical considerations</p> <p>Does the program or strategy meet equal opportunity and human right requirements?</p> <p>Would delivery of the program or strategy constitute research, i.e. would it need ethics approval?</p>	

Appendix D Budget templates

Budget template 1

Overall IHP budget breakdown	
1. IHP staffing costs	
1a) IHP staffing budget	\$
1b) Total IHP equivalent full time (EFT)	
1c) Number of positions funded	
2. Other program costs	
2a) internal (e.g. development of program materials)	\$
2b) external (e.g. providing grants to other organisations/community groups)	\$
TOTAL	\$

Note: Agencies contributing IHP funding towards a Healthy Together Community (HTC) should indicate the total budget and EFT allocated to the HTC. Agencies contributing 100 per cent of funds to a HTC are still required to complete budget template 1.

Budget template 2

Summary of IHP budget by objective	
Priority 1	Estimated \$ expenditure
Objective 1	
Evaluation	
Objective 2	
Evaluation	
Objective 3	
Evaluation	
Priority 2	Estimated \$ expenditure
Objective 1	
Evaluation	
Objective 2	
Evaluation	
Objective 3	
Evaluation	
Priority 3	Estimated \$ expenditure
Objective 1	
Evaluation	
Objective 2	
Evaluation	
Objective 3	
Evaluation	
TOTAL	\$