Evaluation of Latrobe Health Innovation Zone, Latrobe Health Assembly and Health Advocate
Draft consultation evaluation framework
06 November 2017
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## Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AES</td>
<td>Australasian Evaluation Society</td>
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<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<td>AM</td>
<td>Avoidable Mortality</td>
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<td>ACSC</td>
<td>Ambulatory Care Sensitive Conditions</td>
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<td>DHHS</td>
<td>Department of Health and Human Services</td>
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<td>EFHIA</td>
<td>Equity Focused Health Impact Assessment</td>
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<td>ELF</td>
<td>Early Life Follow-Up</td>
</tr>
<tr>
<td>EQ</td>
<td>Evaluation Question</td>
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<td>GPHN</td>
<td>Gippsland Primary Health Network</td>
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<tr>
<td>HAZ</td>
<td>Health Action Zone</td>
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<td>HHS</td>
<td>Hazelwood Health Study</td>
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<td>HTV</td>
<td>Healthy Together Victoria</td>
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<td>IA</td>
<td>Impact Area</td>
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<td>LCC</td>
<td>Latrobe City Council</td>
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<td>LGA</td>
<td>Local Government Area</td>
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<td>LHA</td>
<td>Latrobe Health Assembly</td>
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<td>LHIZ</td>
<td>Latrobe Health Innovation Zone</td>
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<tr>
<td>LO</td>
<td>Long Term Outcome</td>
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<tr>
<td>MO</td>
<td>Medium Term Outcome</td>
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# Glossary

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tr>
<td>MPHWP</td>
<td>Municipal Public Health and Wellbeing</td>
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<tr>
<td>NGO</td>
<td>Non-Government Organisation</td>
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<tr>
<td>OHCC</td>
<td>Ontario Healthy Communities Coalition</td>
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<tr>
<td>PHS</td>
<td>Preventive Health Survey</td>
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<tr>
<td>PID</td>
<td>Project Initiation Document</td>
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<td>PTSD</td>
<td>Post Traumatic Stress Disorder</td>
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<tr>
<td>SO</td>
<td>Short Term Outcome</td>
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<tr>
<td>UK</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>VPHS</td>
<td>Victorian Population Health Survey</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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Executive summary
This consultation draft document describes the developmental evaluation framework that has been developed to evaluate the Latrobe Health Innovation Zone, the Latrobe Health Assembly and the Latrobe Health Advocate (the initiatives).

**Why are we doing this?**
The purpose of a developmental evaluation is to:

- **Improve programs while they occur**, and focus less on assessment at their end; and
- **Actively include the community and people who are part of the program** in deciding if the objectives have been, or are on track to being achieved.

By having an evaluation in place, the community will have an opportunity to **have their say** on whether the initiatives are having the impact people wanted them to have.

This will mean that successes will be celebrated as they happen and opportunities to improve things will be identified as new things are tried.
HOW WAS THE FRAMEWORK DEVELOPED?

- **34 stakeholder meetings in Latrobe**
- **6 sessions** with the Assembly and Assembly working groups
- **Over 90 responses** to the community survey
- **5 media mentions** including WIN News & 4 Latrobe Valley Express stories
- **Over 7000 people reached through Facebook**
- **4 community workshops** attended by more than 50 people
WHAT IS THE EVALUATION FRAMEWORK?

The evaluation framework describes:

• What the community wants these initiatives to do (outcomes); and
• The questions the evaluation will help to answer.

Over time, the community wants the initiatives to do four main things:

1. IMPROVE COMMUNITY OPPORTUNITIES AND PERCEPTIONS

2. IMPROVE COMMUNITY CONNECTEDNESS AND PARTICIPATION

3. IMPROVE HEALTH SERVICE ACCESS AND DESIGN

4. IMPROVE HEALTH AND LIFESTYLE
## WHAT ARE THE INITIATIVES BEING EVALUATED?

### LATROBE HEALTH INNOVATION ZONE

The **Latrobe Health Innovation Zone** is the first of its kind in Australia. The Zone is the place in which voice is given to community aspirations in the planning and delivering of better health and wellbeing outcomes. It is the place in which a process of co-design that actively engages with individuals and organisations is encouraged.

### LATROBE HEALTH ASSEMBLY

The **Latrobe Health Assembly** will provide input and direction for health initiatives within the Latrobe Health Innovation Zone. It will facilitate new ways of working to enable the community, local and state-wide agencies and government to work together to improve health and wellbeing in Latrobe.

### LATROBE HEALTH ADVOCATE

The **Latrobe Health Advocate** will provide independent community-wide leadership within the Latrobe Health Innovation Zone by enabling, mediating and advocating for health and wellbeing (the Advocate is soon to be appointed).
WHAT DOES THE COMMUNITY WANT THE ZONE TO DO?

1. **IMPROVE COMMUNITY OPPORTUNITIES AND PERCEPTIONS**
   - **SHORT TERM (2018)**: Different sectors invest in new ways of working
   - **MEDIUM TERM (2019-20)**: New ways of working improve the opportunities available
   - **LONG TERM (2021-22)**: Improved opportunities improve perceptions of Latrobe

2. **IMPROVE COMMUNITY CONNECTEDNESS AND PARTICIPATION**
   - **SHORT TERM (2018)**: The community participate in programs for the Zone
   - **MEDIUM TERM (2019-20)**: The community lead programs for the Zone
   - **LONG TERM (2021-22)**: The community are more resilient

3. **IMPROVE HEALTH SERVICE ACCESS AND DESIGN**
   - **SHORT TERM (2018)**: Health and wellbeing service providers think about how they can work together
   - **MEDIUM TERM (2019-20)**: “No wrong door” - community members get the help they need no matter who they contact first
   - **LONG TERM (2021-22)**: Improved service integration means more health and wellbeing service providers want to work in the Zone

4. **IMPROVE HEALTH AND LIFESTYLE**
   - **SHORT TERM (2018)**: The community are aware they are in the Zone when making choices related to their health and wellbeing
   - **MEDIUM TERM (2019-20)**: The community make positive changes to their health and wellbeing behaviours
   - **LONG TERM (2021-22)**: The community has a culture of healthy living and improved health outcomes
WHAT DOES THE COMMUNITY WANT THE ASSEMBLY TO DO?

1. IMPROVE COMMUNITY OPPORTUNITIES AND PERCEPTIONS
   - **SHORT TERM** (2018): Different sectors plan, develop and implement ways to improve local opportunities
   - **MEDIUM TERM** (2019-20): The community has improved access to opportunities
   - **LONG TERM** (2021-22): Improved opportunities improve perceptions of Latrobe

2. IMPROVE COMMUNITY CONNECTEDNESS AND PARTICIPATION
   - **SHORT TERM** (2018): The community are supported to lead community programs
   - **MEDIUM TERM** (2019-20): The community feel trusted and empowered to lead community programs
   - **LONG TERM** (2021-22): The community has improved capacity to lead community programs

3. IMPROVE HEALTH SERVICE ACCESS AND DESIGN
   - **SHORT TERM** (2018): Health and wellbeing service providers plan ways to address local service gaps
   - **MEDIUM TERM** (2019-20): The community has improved access to health and wellbeing services
   - **LONG TERM** (2021-22): The community are confident that they, their family and their friends can access the services they need, when they need them

4. IMPROVE HEALTH AND LIFESTYLE
   - **SHORT TERM** (2018): The community has improved access to health and wellbeing educational materials
   - **MEDIUM TERM** (2019-20): The community has improved health and wellbeing behaviours
   - **LONG TERM** (2021-22): The community has improved health outcomes including reduced chronic disease and mental health
WHAT DOES THE COMMUNITY WANT THE **ADVOCATE** TO DO?

1. **IMPROVE COMMUNITY OPPORTUNITIES AND PERCEPTIONS**
   - **SHORT TERM**
     - Latrobe and the community’s needs are better represented to decision makers
   - **MEDIUM TERM**
     - Decision makers understand the positives of Latrobe and the community’s needs
   - **LONG TERM**
     - The community has improved confidence in the abilities of decision makers to meet their needs

2. **IMPROVE COMMUNITY CONNECTEDNESS AND PARTICIPATION**
   - **SHORT TERM**
     - The community are confident that the Advocate represents their needs
   - **MEDIUM TERM**
     - The community feel empowered to advocate for their health and wellbeing needs
   - **LONG TERM**
     - The community has greater capacity to advocate for their health and wellbeing needs

3. **IMPROVE HEALTH SERVICE ACCESS AND DESIGN**
   - **SHORT TERM**
     - The Advocate is respected by health and wellbeing decision makers and communicates the community’s needs
   - **MEDIUM TERM**
     - The community has improved access to health and wellbeing services
   - **LONG TERM**
     - The community are confident that they, their family and their friends can access the services they need, when they need them

4. **IMPROVE HEALTH AND LIFESTYLE**
   - **SHORT TERM**
     - The Advocate is a health and wellbeing leader
   - **MEDIUM TERM**
     - The community has improved health and wellbeing behaviours
   - **LONG TERM**
     - The community has a culture of healthy living
## WHAT QUESTIONS DO THE COMMUNITY WANT ANSWERED?

<table>
<thead>
<tr>
<th>What is <strong>going well?</strong> Why?</th>
<th>How is the initiative <strong>suited to improving health and wellbeing?</strong></th>
<th>Did the initiative <strong>work together with the community</strong> and other people?</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is <strong>not going well?</strong> Why?</td>
<td>Are community members <strong>aware</strong> of the initiative?</td>
<td>Did the initiative <strong>meet the community’s needs?</strong></td>
</tr>
<tr>
<td><strong>What could be improved</strong>, why and how?</td>
<td>Do community members <strong>understand</strong> the initiative’s purpose?</td>
<td>Did the initiative <strong>improve health and wellbeing</strong> in Latrobe?</td>
</tr>
<tr>
<td>How is the initiative doing <strong>innovative things?</strong></td>
<td>How are community members <strong>involved</strong>?</td>
<td>Do community members want the initiative to <strong>continue?</strong></td>
</tr>
<tr>
<td>How is the initiative learning from existing <strong>evidence</strong>?</td>
<td>Is the initiative doing things <strong>too quickly, too slowly or just right?</strong></td>
<td>Could the initiative be <strong>tried somewhere else?</strong></td>
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WHEN WILL THE EVALUATION PROVIDE FEEDBACK & REPORTS?

**May 2017:**
Start co-designing the evaluation framework with the community

**November 2017:**
Share the draft consultation evaluation framework for public comment

**June 2018:**
Share the interim report

**March 2020:**
Share the final report

Regular informal feedback will be shared regarding early progress and opportunities for improvement
HOW CAN THE COMMUNITY GET INVOLVED?

Like the evaluation Facebook page and share it with your friends and family!

https://www.facebook.com/LHIZeval/

Complete the evaluation community survey.

This will be launched soon after the start of the evaluation in 2018.

Attend an evaluation community workshop or forum.

Details will be shared soon after the start of the evaluation in 2018.

If you have any questions or feedback regarding the evaluation, please contact Deloitte via

LHIZeval@deloitte.com.au
Thank you to all the Latrobe community members who gave up their time to contribute to the development of the draft evaluation framework.
1. Background and purpose
Purpose of the evaluation
Evaluation of the Latrobe Health Innovation Zone, Latrobe Health Assembly and the position of the Latrobe Health Advocate

In May 2017, Deloitte was engaged by the Department of Health and Human Services (DHHS) to conduct a developmental evaluation of the Latrobe Health Innovation Zone (the Zone), the Latrobe Health Assembly (the Assembly) and the position of the Latrobe Health Advocate (the Advocate) – referred to collectively within this document as the “Latrobe health initiatives”.

To do this, Deloitte, with assistance from First Person Consulting, will work with the Latrobe community (the community), agencies, business, government, the Latrobe Health Assembly and the Latrobe Health Advocate.

The first step in this is to work with the community and others to design the evaluation. In doing so, the community are being given the opportunity to have their say on the things they would like these initiatives to achieve.

This step is underway. Emerging priorities of what the community would like the Latrobe Health Innovation Zone, Latrobe Health Assembly and the Latrobe Health Advocate to achieve are described in this document; consultation draft of the evaluation framework. The draft evaluation framework will be presented to the November 2017 Assembly meeting for discussion.

The next step will then be to work with the community and others to actually carry out the evaluation. This will start from late 2017. The information that is collected will be used to make suggestions that can assist these initiatives to best meet the community’s needs. There will be opportunities for the community to provide feedback about the evaluation so that it can continue to improve its approach over time.

The project started in May 2017 and is expected to continue until 2020. Regular updates on current activities and findings are being provided through the Latrobe Health Innovation Zone Evaluation Facebook page and other media.

In essence, the project is an opportunity for the community to influence the impact of these initiatives. This, in turn, will help improve health and wellbeing in the Latrobe.
Purpose of the evaluation
Developmental evaluation informs ongoing program development

**Developmental evaluation** uses **real-time information** to support **social innovation**. It does this by **learning** from things as they occur and providing **feedback** to inform **positive change** (Quinn-Patton, 2008).

This is appropriate for the evaluation of the Latrobe health initiatives because they represent an **innovative and community driven approach** to positively influencing health and wellbeing outcomes in Latrobe.

To be innovative, **new approaches and ways of working are expected to be tried**. The evaluation will look at what has been tried to understand what seems to have worked well and what has contributed to this. There is also a possibility that some things may not work as well and may be able to improve. The evaluation will share these insights and learnings so they may be incorporated in the future.

The **evaluation is an opportunity for the Assembly, Advocate and Latrobe community**.

Engagement with the community throughout the project will provide the Assembly and Advocate with:

- Another source of community views regarding **health and wellbeing priorities**;
- Another source of community views regarding what they would like the Zone, the Assembly and the Advocate **to focus on or contribute towards**; and
- Community feedback on what they **know** about these initiatives, **how they feel they are going** and what (if anything) they would like changed.

The evaluation will consider the implementation of these initiatives, the work they are doing and the impact they are having. In doing this, **the evaluation can provide helpful feedback for consideration** by the Assembly and Advocate. This will be done in a constructive way with no surprises. The evaluation itself will **involve community members**. For example, to contribute towards the evaluation and develop skills, community members (including Assembly members) may assist in workshop facilitation and data collection.

The evaluation will continue to provide the community with **regular updates** through the Facebook page and other methods as well as to the Assembly, the Advocate and DHHS. This will mean that people **can see how the information they have provided is being used**. It will also mean the evaluation is **transparent and interactive**.
Purpose of the evaluation framework
The audience for this document is the Latrobe community, the Assembly, the Advocate and DHHS

This consultation draft of the evaluation framework describes the outcomes that the Zone, Assembly and Advocate may contribute towards. This has been developed through a consultative process involving the Latrobe community and the Assembly (the Advocate is yet to be appointed). This document is current as of November 2017. However, it is anticipated that the framework will be a living document that will be revised throughout the evaluation, particularly in its first year and following completion of the interim report in 2018.

The evaluation framework describes how these initiatives may effect change in the impact areas identified by the community. This approach has been chosen over an experimental or quasi-experimental approach due to the broad overarching objective of the Latrobe health initiatives and their formative nature. It is also unlikely that a meaningful comparison or control group could be developed, although it may be possible to draw upon other research that has utilised this design for analysis of selected initiatives or indicators. The below diagram demonstrates the relationships that exist between the key elements of the framework.

Evaluation objective
The evaluation will consider the implementation of these initiatives, the work they are doing and the impact they are having. In doing this, the evaluation can provide helpful feedback for consideration by the Assembly and Advocate. This will be done in a constructive and developmental way, with no surprises.

Evaluation model (pg. 37)
Outlines the evaluation model i.e. what are the activities and what is their expected impact.
- The evaluation model includes:
  - Inputs
  - Activities
  - Outputs
  - Short, medium and long term outcomes
  - Impacts.

Evaluation questions (pg. 44)
The evaluation questions are informed by the evaluation model. They define the scope and focus of the evaluation.
- The evaluation questions relate to:
  - Appropriateness
  - Effectiveness
  - Sustainability.

Data requirements and approach to data collection and analysis (pg. 49)
Each piece of data will be aligned to an evaluation question to assist in answering that question. Qualitative and quantitative data will be collected from a variety of primary and secondary sources.
Scope of the evaluation

The Latrobe Health Innovation Zone community is comprised of many diverse communities and groups, these are referred to collectively throughout this document as “the community”

The geographic area of the Latrobe Health Innovation Zone is shown beside. This area is aligned with Latrobe City Council boundaries. The community is considered to be people who live, work and study within the Zone. It is recognised that:

- People travel inside, and outside, of the Zone for work and to access services, however, these people may still have a stake in health and wellbeing in Latrobe; and
- The health and wellbeing of the community may be influenced by programs, services and other factors located outside of the Zone.

Some features of the City of Latrobe from the 2016 Census are shown below. These will be accounted for during sampling and data collection methodologies for the evaluation, noting that it is important to ensure representative participation in the evaluation.

- 1,184 (1.6%) of people are Aboriginal and/or Torres Strait Islander
- There are 2,694 (8.9%) of households where a non-English language is spoken. Other languages spoken at home included Italian 1.1%, Greek 0.5%, Mandarin 0.4%, Dutch 0.3% and Maltese 0.3%
- 3,744 (19.9%) of families are one parent families
- 5,507 (19.5%) of dwellings (homes) have no internet access
- Some cohorts of the community will not have been captured by the Census and require local knowledge to identify and reach.

Full details of the demographic data and other community characteristics from the 2016 Census comparing City of Latrobe to the whole of Victoria are included in appendix A.
The overarching objective of the Latrobe health initiatives is to improve health and wellbeing in Latrobe. How is health and wellbeing defined?

The preamble to the World Health Organisation (WHO) Constitution states that “health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity...informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people”.

The Australian Institute of Health and Wellbeing (AIHW) echoes this broad view of health, stating that “health, or being in good health, is important to everyone. It influences not just how we feel, but how we function and participate in the community.” The Latrobe community has expressed a similarly broad view of health and wellbeing throughout the consultative process undertaken to design the evaluation framework. The breadth of this view is reflected in the evaluation models for these initiatives.

The AIHW has developed a model for describing the determinants that influence a person’s health and wellbeing over-time:

The AIHW framework shown demonstrates the many factors that influence health.

The arrows indicate relationships between these determinants. These arrows show that one or more determinants may influence, or be influenced by, another determinant. For example, the factors comprising a person’s environment will influence various socioeconomic characteristics such as access to services.

The many relationships displayed in the AIHW framework emphasise the importance of adopting a holistic approach when seeking to improve a person’s health and wellbeing.

The evaluation recognises this and has considered the AIHW framework along with other sources, including community consultation, in developing this evaluation framework.
Background
Health and wellbeing in Latrobe

**Strengths of the Latrobe**

Despite its current challenges, Latrobe has many strengths which should be recognised and celebrated.

The Latrobe City Council’s draft *Municipal Public Health and Wellbeing Plan 2017-2021* observes these strengths:

- **Our people** – Welcoming, diverse, supportive, cooperative, resilient, caring and connected – we look after each other.
- **Our place** – Natural beauty, liveability, active living, services and pride of place.
- **Our opportunity** – People are listening, time of change, goodwill, our future is bright, our youth.

The Latrobe City Council also conducted a post mine fire doorknock survey in the Morwell North area. The report from this survey contains the residents’ perceived strengths of the area:

- 58% of respondents rated the community as “good”, with 26% rating it as “excellent”.
- 22% of respondents selected that they liked the quietness of the area the most.
- 37% of respondents reported that they know their neighbours well, with 89% indicating they would be happy to ask them for help.

While the population for this survey was confined to the Morwell North area, the pride of place demonstrated in the reported responses has been echoed throughout the consultation conducted in developing the draft consultation evaluation framework.

**Health and wellbeing challenges in Latrobe Valley**

The Hazelwood coal mine fire burned for 45 days in February and March 2014.

The subsequent *Hazelwood Mine Fire Inquiry* has drawn attention to the poorer health and adverse socioeconomic outcomes experienced by residents of Latrobe, both leading up to and after the disaster. With the *Hazelwood Mine Fire Inquiry Report 2015/2016 Volume 3* stating that “amongst communities of Latrobe, more years of life will be lost on average than in other Victorian communities as a direct result of conditions such as cancer, diabetes, mental disorders, cardiovascular disease, asthma and injuries”.

In this report, **chronic disease and mental health** were highlighted as key areas for improvement in Latrobe.

Mental health organisations noted that the economic upheaval in Latrobe, along with growing levels of social isolation, has led to relatively poorer mental and physical health in Latrobe.
Background
Health and wellbeing in Latrobe

This is further supported by the Victorian Population Health Survey, reporting that the Latrobe LGA has:

- **High rates of obesity**: 24% of residents are obese; higher than Gippsland (20%) and Victoria (17%).
- **High levels of Type 2 Diabetes**: 7% of people report Type 2 diabetes; higher than Gippsland (5.4%) and Victoria (5.0%).
- **High rates of psychological distress**: 17% of people report high or very high psychological distress; compared to Victoria (12%).

This is further reflected by the differences in life expectancies in Latrobe compared with Victoria:

- **Males** in Latrobe have a life expectancy of 76.9 years compared with 80.3 years for males in Victoria.
- **Females** in Latrobe have a life expectancy of 82.2 years compared with 84.4 years for females in Victoria.

**The long term Hazelwood Health Study**

The Victorian Government commissioned the Hazelwood Health Study in response to the Hazelwood coal mine fire.

The aim of the Hazelwood Health Study is to “undertake a long term study into the potential long term health effects from the Hazelwood coal mine fire”.

The focus of the study is to measure the effects of smoke exposure on cardiovascular disease, respiratory illness, cancer and psychological impacts for people living in Morwell and the broader Latrobe Valley, especially vulnerable groups like children and older people. In addition to providing evidence which will inform health service planning in the region.

Monash University leads the consortium of research organisations undertaking the Hazelwood Health Study over the next 20 years.

The Hazelwood Health Study has examined chronic disease and mental health outcomes among adults and children affected by the mine fire.

Study findings so far have included the following based on **self reported** data:

- Residents in Latrobe were more likely to be diagnosed with PTSD, and school-aged children at the time of the fire showed higher levels of symptoms associated with PTSD.
- Residents showed higher blood pressure readings on average, as well as respiratory symptoms associated with bronchitis and rhinitis. Asthmatic symptoms were also more severe.
Background
The Government’s response to the Hazelwood Mine Fire Inquiry

In line with their response to the Hazelwood Mine Fire Inquiry Board recommendations – as outlined in the Hazelwood Mine Fire Inquiry: Victorian Government Implementation Plan – the Victorian Government has established the Latrobe Health Innovation Zone which is the first of its kind in Australia.

The Latrobe Health Innovation Zone is the place in which voice is given to community aspirations in the planning and delivering of better health and wellbeing outcomes. It is the place in which a process of co-design that actively engages with individuals and organisations is encouraged.

Key components of the Latrobe Health Innovation Zone include:

• The Latrobe Health Assembly will provide input and direction for health initiatives within the Latrobe Health Innovation Zone. It will facilitate new ways of working to enable the community, local and state-wide agencies and government to work together to improve health and wellbeing in Latrobe; and

• The position of the Latrobe Health Advocate will provide independent community-wide leadership within the Latrobe Health Innovation Zone by enabling, mediating and advocating for health and wellbeing (the Advocate is soon to be appointed).
The Latrobe Health Innovation Zone
The first of its kind in Australia

The Latrobe Health Innovation Zone

The purpose of creating a Latrobe Health Innovation Zone is to improve the health and wellbeing of the Latrobe community by:

- Providing a focal point for the coordination and integration of health services;
- Driving innovation in the development and delivery of health services and health improvement programs;
- Engaging the Latrobe community through the Assembly to work with Latrobe City Council, local agencies, business leaders and Government to identify local health priorities and implement health programs;
- Increasing preventive health initiatives to encourage a culture of healthy living in Latrobe;
- Improving access to intervention and screening programs for early identification of health conditions;
- Promoting innovative approaches to create better awareness of and access to mental health services so people in need are able to reach out when they need help;
- Promoting better chronic disease management so people have the assistance they need to manage their health concerns; and
- Improving access to specialist health services so patients can access specialist services without long commutes (adapted from Hazelwood Mine Fire Inquiry Report 2015/2016 Volume 3 and Hazelwood Mine Fire Inquiry: Victorian Government Implementation Plan).

The Zone, in itself, is not an entity and has no dedicated resources. How the Zone materialises in practice, is dependent on the actions of key stakeholders within the Zone including the community, the Assembly, the Advocate, DHHS and key health and wellbeing related organisations in Latrobe, many of whom are on the Board of the Assembly.

The designation of the Zone, for example, may lead to positive change in the behaviour and coordination of these groups and their initiatives, and a greater sense that health and wellbeing is important in Latrobe.

The relationship between the Zone, the Assembly and the Advocate is in a formative stage. It is expected that the roles and responsibilities of each initiative will be further refined and clarified upon completion of the charter, and the commencement of the Advocate.
Review of similar initiatives to the Zone
A targeted review of similar initiatives and evaluations has been undertaken to inform the evaluation, please refer to appendix B for more detail

The Healthy Cities Movement

The Ottawa Charter for Health Promotion (WHO, 1986) defines health promotion as “the process of enabling people to increase control over, and to improve their health” (WHO, 1986). Since its inception, the Ottawa Charter has been a seminal resource for a “new public health movement around the world” (WHO, 1986).

In the Ottawa Charter, the World Health Organisation (WHO) asserted that “the prerequisites and prospects for health cannot be ensured by the health sector alone” and called for “coordinated action by all concerned: by governments, by health and other social and economic sectors, by non-governmental and voluntary organizations, by local authorities, by industry and by the media” (WHO, 1986).

Frameworks for building healthy cities and communities

There are a number of major health promotion interventions around the world that have been developed to implement the principles outlined in the Ottawa Charter through activities aimed at building healthy cities. The most relevant of these include:

• The WHO Healthy Cities project
• Health Action Zones in the UK
• Healthy Cities Noarlunga pilot.

Evaluations of similar health promotion initiatives

In reviewing the evaluations of the WHO Healthy Cities movement to date, de Leeuw (2013) advocates for a realist approach to evaluation and proposes the following questions for evaluating impact:

• To what extent can a specific (net) impact be attributed to the intervention?
• Did the intervention make a difference?
• How has the intervention made a difference?
• Will the intervention work elsewhere?

Evaluation of Health Action Zones

In 1997, the UK Government introduced a large long term initiative (7 years) to tackle health inequity. Health Action Zones (HAZs), built upon multiagency partnership agreements, were established in 26 areas where high levels of social disadvantage were recorded. The Judge, et al. (1999) report of the national evaluation notes a number of common problems in the identification of the HAZs anticipated outcomes, such as failure to specify:

• What the starting point is
• The scale of change aspired to
• The end point
• The specific groups or areas concerned.
Review of similar initiatives to the Zone
A targeted review of similar initiatives and evaluations has been undertaken to inform the evaluation, please refer to appendix B for more detail

The report did however include some “good examples of HAZ planning”. These included the following features:

- The HAZ had an overall vision statement or clear plan
- These plans included a logical pathway from vision to themes, objectives and targets
- Clear statements of what success would look like at time points in the future were included
- Projects were described in detail along with outlines of what is expected/hoped for by short, medium and long term time points (Judge, et al., 1999).

Evaluation of the Healthy Cities Noarlunga pilot

The Healthy Cities approach was piloted in Australia in the Healthy Cities Noarlunga project, commencing in 1987. Evaluation data was collected throughout the project.

Baum and Cooke (1992) reported outcomes in each of the following areas:

- Built healthy public policy
- Created supportive environments
- Strengthened community action
- Developed personal skills
- Reorientated health services toward prevention of illness and health promotion.

Achievements were attributed to listening to the voice of community and taking advantage of and harnessing the “political issues of the time” (Baum & Cooke, 1992).

What does this mean for the evaluation of the Latrobe health initiatives?

The learnings from the evaluations of international and local efforts to improve the health and wellbeing of cities and communities have been incorporated into our approach to designing and conducting the evaluation framework for the Latrobe Health Innovation Zone.

Namely, the evaluations of the WHO Healthy Cities project, the UK Health Action Zones and the Healthy Cities Noarlunga pilot have emphasised the need for the evaluation to have a greater focus on the new ways of working employed by the initiative to effect change, the early signs of success these are showing, as well as potential areas for improvement. This is in contrast to a more outcomes focussed approach, noting that changes in health outcomes can take many years to occur.
The Latrobe Health Assembly
A key component of the Latrobe Health Innovation Zone

The Latrobe Health Assembly

The Latrobe Health Assembly is comprised of up to 50 members and is overseen by a ten member board. The key functions of the Assembly – as stated in their constitution – are to:

- Lead local health planning and priority setting in active partnership with the local community in Latrobe;
- Engage with the community to determine priorities for investment of new funding and opportunities in Latrobe;
- Create and implement local, community-led responses to priority health issues in Latrobe;
- Assist in the development and design of the role and responsibilities of the Advocate and facilitate the appointment of a Advocate in Latrobe, and then work with the Advocate to champion change;
- Support and improve the design and utilisation of health promotion and prevention initiatives particularly to improve the health of vulnerable groups;
- Work with the community to promote healthy living including the built environment, active and passive open space and leisure services;
- Support and improve the design and utilisation of care pathways to improve coordination and integration of services for people with chronic diseases;
- Work with the community to identify priorities around access to specialist health services and provide advice on innovative opportunities, solutions and implementation approaches;
- Embed community engagement through all elements of its operation and seek to drive greater community engagement in the broader healthcare system in Latrobe; and
- Collect and report on progress made and outcomes achieved, work with local partners and the community to identify what indicators will be meaningful and useful to achieve its purpose.

The Assembly meet quarterly and had their first meeting in 2016. The Board meets monthly. The Assembly members have formed four working groups which also meet monthly: (1) Pride of place, (2) Chronic illness and wellness, (3) Make a move, (4) Early childhood, families and youth.

The Assembly office has an Executive Officer and three additional dedicated personnel. The office has developed a project management framework to provide a clear and concise approach to project management for the Assembly; detailing the process from idea conception to business case development, pilot initiation and project expansion. A number of Project Initiation Documents (PIDs) are in development. A branding exercise is also underway. Upon the addition of 4 community members to the Assembly Board, it is expected the Assembly will complete a strategic planning exercise regarding what outcomes the Assembly wants to achieve, can realistically achieve and how they plan to achieve them.
The Latrobe Health Advocate
A key component of the Latrobe Health Innovation Zone

The Latrobe Health Advocate

In the 2014 Hazelwood Mine Fire Inquiry Report, the Board recommended that a Health Advocate be appointed to provide “advice, mediation and advocacy on health-related matters’ for the community”.

The Advocate will report to the Minister for Health. The objective of the Advocate, as described by DHHS, is to provide independent advice to the Victorian Government on behalf of the Latrobe community on system and policy issues affecting their health and wellbeing. They will also provide community-wide leadership for the Latrobe Health Innovation Zone by enabling, mediating and advocating for health improvements through health and broader system improvements and change. This model has been approved by the Minister and is similar to that recommended by the inquiry.

To deliver on these objectives, the key functions of the Advocate are to:

- Research, monitor and report on current and emerging issues affecting the health and wellbeing of Latrobe residents;
- Provide strategic advice and informed and collaborative leadership on health-related matters in Latrobe;
- Enable, advocate and mediate system change and improvement to address barriers or improve opportunities for good health and wellbeing in Latrobe;
- Provide leadership and an independent public voice to engage directly with the community about health matters, particularly more marginalised members of the community;
- Actively engage and adopt a collaborative approach with stakeholders across the community in executing its terms of reference including community members, business, industry, agriculture, health services, community organisations, and all levels of government; and
- Engage and work collaboratively with DHHS, the Assembly and Latrobe Long Term Health Study Ministerial Advisory Committee as relevant.

The Advocate is yet to be appointed. As such, it is expected that the exact activities and outcomes of the Advocate will be further refined and clarified upon the appointment and commencement of this position.

The WHO defines health advocacy as a “combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular health goal or programme” (WHO, 1995).

As such, the evaluation of the Latrobe Health Advocate will need to consider the extent to which the Advocate represents the Latrobe community in the processes they undertake to influence policy decisions.
Other programs of work
There are many of concurrent and interrelated programs of work in Latrobe which the evaluation needs to be aware of.

There are many concurrent and interrelated programs of work in Latrobe. These include programs conducted by the Latrobe City Council, Latrobe Community Health Service, Gippsland Primary Health Network, Latrobe Regional Hospital, Latrobe Valley Authority, the Hazelwood Health Study and other evaluations.

Many of these will have an impact on the health and wellbeing of the Latrobe community. The evaluation needs to be aware of these streams of work both as they relate to the ongoing, iterative design of the evaluation framework and in conducting the evaluation.

The most relevant programs of work to the evaluation are summarised below. This is not an exhaustive list.

**Latrobe City Council (LCC)**

The LCC are in the process of finalising the *Municipal Public Health and Wellbeing Plan 2017-2021*. The draft of this report was kindly shared with the evaluation team and identifies the following key areas of focus relating to health and wellbeing:

- Social and community connectedness
- Safe at home
- Safe in our community
- Active living
- Healthy living
- Lifelong learning and opportunities.

**Gippsland Primary Health Network (GPHN)**

The GPHN has been contracted by DHHS to support and implement deliverables 69-77 of the *Hazelwood Mine Fire Inquiry: Victorian Government Implementation Plan* relating to early detection and screening including smoking cessation.

**Hazelwood Health Study (HHS)**

The HHS commenced in November 2014 with the intent of identifying potential health outcomes in the community which may have resulted from the smoke of the Hazelwood Mine Fire. The study will focus on the following research streams:

- Community wellbeing
- The Latrobe ELF study
- Older people
- Schools study
- Adult survey
- Air quality assessment
- Follow up health and psychological assessments
- Linkage to health records including hospital, ambulance and cancer.

**Other Hazelwood Mine Fire Inquiry: Victorian Government Implementation Plan deliverables and evaluations**

For instance, the evaluation of Latrobe Health Innovation Zone mental health and chronic disease pilots (deliverable 85) is expected to commence in late 2017.
Methodology for developing the evaluation framework

How have we worked with the community and others to design the evaluation framework?

AT A GLANCE

34 stakeholder meetings in Latrobe
6 sessions with the Assembly and Assembly working groups
4 community workshops attended by more than 50 people
Over 90 responses to the community survey
5 media mentions including WIN NEWS, Latrobe Valley Express
Over 7000 people reached through Facebook

Phase 1
- Conducted preliminary conversations
- Attended LHA Board meeting

May - June - July - August - September - October - November - December
- Attended the LHA meeting on the 6th of June
- Met with 23 community stakeholders and groups during May through to the end of July
- Attended the LHA Board meeting on the 6th of June
- Attended the LHA meeting on the 1st of August

Phase 2
- Commenced working at LHA office (approx. one day per week)
- Conducted community and other stakeholder consultations

- Launched LHIZ evaluation Facebook page
- Launched health and wellbeing survey
- Conducted community workshops

- Attended LHA working group meetings
- Attend LHA meeting
- One Deloitte team member works from the LHA office approximately one day per week
- Met with 6 community stakeholders and groups with 5 more scheduled

Phase 3
- DRHS to commence public consultation
- Finalise and deliver the evaluation framework

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Methodology for developing the evaluation framework
What have we heard the community say?

How does the community want these initiatives to improve health and wellbeing in Latrobe?

Four impact areas have emerged regarding how the community would like these initiatives to improve health and wellbeing in Latrobe. The breadth of these impact areas demonstrate the community’s holistic and interrelated perception of health and wellbeing.

These impact areas have informed the development of the evaluation framework.

Impact area 1 (IA1): Improved community opportunities and perception

- "Pride of place"
- Making Latrobe Valley a destination of choice
- Celebrating the positives of the area and recognising that it is a wonderful place to study, work and live
- Improving local employment and education opportunities, because health and wellbeing depends on having a job.

Impact area 2 (IA2): Improved community connectedness and participation

- Community-led and owned programs
- Building relationships and connections with others
- Strengthening community bonds and resilience.

Impact area 3 (IA3): Improved health service access and design

- Fairer, faster and easier access to local, affordable, culturally appropriate health services, including mental health services, alcohol and drug services, dental services, youth services, aged care and hospice service, preventive health services, primary health services, and other specialists
- Adopting a “no wrong door” approach to accessing health services, meaning health services are more integrated to ensure community members are put in touch with the correct service regardless of who they contact in the first instance.

Impact area 4 (IA4): Improved health and lifestyle

- Improving health outcomes
- Improving understanding what good health means
- Improving opportunities for healthy choices including healthy food options, physical activity options and environments that support healthy lifestyles
- Reducing exposure to negative influences such as alcohol, junk food, gambling, racism, sexism, violence, bullying, discrimination.

Another key theme that has emerged from what we have heard the community say is “getting on with it” and acting in a timely manner with integrity and honesty. This theme has been captured in the evaluation questions in section 3.
Methodology for developing the evaluation framework

What have we heard the community say?

**What does the community want the evaluation to do?**

- Help the community to **have their say** about health and wellbeing in Latrobe
- **Give** the community a voice in what these initiatives do and how they do it
- Help the community to **give feedback** on these initiatives
- **Understand** what has improved and what other things can be done
- Help the Latrobe Health Assembly **have an impact** on health inequities within Latrobe
- **Listen** to the community – ask what they need, come to places where the community gathers and **talk to people**
- **Be accessible** to all members of the community – share **stories** from people who are benefiting

These points have influenced the design of the evaluation questions in section 3.
What does this mean in terms of the evaluation?

The following principles were drafted following early insights obtained from preliminary stakeholder conversations, these will continue to inform out approach to conducting the evaluation.

The Latrobe health initiatives are an innovative and community driven approach to improving the health and wellbeing of the Latrobe community. It can take many years, or even decades, to influence health outcomes. The evaluation will be conscious of this and, consistent with a developmental approach, will look at the processes followed by the initiatives to help understand whether they are on the right track. This is an opportunity for shared learning and insight.

The evaluation will provide an avenue for ongoing community feedback to ensure the health and wellbeing needs of the Latrobe community are met. To reflect this, our approach to designing the evaluation framework has been guided by the following principles. These principles will continue to guide the evaluation.

- **Being present** in Latrobe and forming trusting relationships with the community;
- **Listening** to and ensuring the community has opportunities to influence the design and outcomes of these initiatives;
- **Linking in** with existing engagement opportunities and communicating through social media such as Facebook and traditional media including local print and radio;
- Working with the community to ensure engagement is representative of the diversity within the Latrobe community, including people who may not hear about the project through traditional channels, such as Aboriginal communities and migrant communities;
- **Being flexible and adaptable** in our approach to engaging with the community to ensure our approach best meets their needs;
- **Being independent** and robust in our evaluation methodology;
- Sharing transparent and timely feedback with the community;
- Recognising existing community strengths; and
- **Recognise** that influencing health outcomes can take many years.

These principles were drafted following early insights obtained from our preliminary stakeholder conversations in phase 1 of our approach. The intent of these preliminary conversations was to inform our approach to designing the evaluation framework and conducting the evaluation.
Quick guide to this document
The evaluation framework forms the core planning document for the subsequent evaluation

8. Data collection tools / instruments
Appendix C contains an example broad community survey.
Appendix D contains an example semi-structured interview guide.

7. Reporting and dissemination
Describes the approach to sharing formal and informal feedback from the evaluation with the Latrobe community, Latrobe Health Assembly, Latrobe Health Advocate and DHHS.

6. Risk assessment and ethics
Provides the Australasian Evaluation Society (AES) principles and guidelines that are particularly relevant to this evaluation.

5. Governance and project management
Provides a brief overview of the governance and project management framework, including reporting and feedback relationships.

4. Data requirements and approach
Details the qualitative and quantitative data that will be brought together from primary and secondary sources to inform the evaluation. These data sources are then linked to the evaluation questions from the previous section.

3. Evaluation questions
Details the evaluation questions that define the scope and focus of the evaluation.

2. Evaluation model
Describes the indicative, point in time draft evaluation models for each of the initiatives based on emerging impact areas of how the community would like the initiatives to improve health and wellbeing in Latrobe.

1. Background and purpose
Provides the background and purpose for the Latrobe Health Innovation Zone, Latrobe Health Assembly, Latrobe Health Advocate and the evaluation. In addition to a summary of the methodology used to develop the framework and how the community would like these initiatives to improve health and wellbeing in Latrobe.
2. Evaluation model
Evaluation model overview
The strategy for achieving intended changes

These evaluation models are a tool to assist in the evaluation of the Latrobe health initiatives. They outline the "building blocks" required for the initiatives to improve health and wellbeing in Latrobe (Morra-Imas and Rist (2009) quote ActKnowledge and Aspen Institute (2003)).

These evaluation models are an indicative, point in time draft that is based on emerging impact areas of how the community would like the Latrobe health initiatives to improve health and wellbeing in Latrobe. In addition to the objectives stated when the initiatives were announced.

The exact outcomes of these initiatives are still being determined. As such, these evaluation models are not intended to identify all the areas that the Latrobe health initiatives will deliver on. Further detail will be added to the evaluation models as these outcomes become more clear.

The evaluation models for the Assembly and Advocate will require consideration by their respective parties. This is expected to occur at the November 2017 Assembly meeting and once the Advocate is appointed.

To assist in developing the principles and outcomes for the Zone, a Charter for the is being developed by Federation University. This is expected to be finalised in December 2017.

**The focus of the evaluation will be the contribution of the Latrobe Health Innovation Zone, Latrobe Health Assembly and the Latrobe Health Advocate to the impact areas identified by the Latrobe community.**
Evaluation model overview

Emerging impact areas of how the community would like the Latrobe health initiatives to improve health and wellbeing in Latrobe

The evaluation models detailed in this document contain the following components:

- **Inputs:** The resources needed to deliver the activities.
- **Activities:** Tasks or actions that use the inputs, including tools, processes or events.
- **Outputs:** The units of service or product delivered, resulting from the activities undertaken.
- **Short term outcomes (year 0-1):** The consequences of the outputs that can reasonably be expected to occur in year 0-1.
- **Medium term outcomes (year 2-3):** The consequences of the outputs that can reasonably be expected in year 2-3.
- **Long term outcomes (year 4-5):** The consequences of the outputs likely to occur in year 4-5.
- **Impacts:** Eventual consequences of the short, medium and long term outcomes extending beyond the line of accountability.

The evaluation will commence year 1 in January 2018 with year 0 representing the time in which these initiatives existed prior to this date.

The short, medium and long term outcomes are linked to evaluation questions in section 5.
Relationship between the Latrobe health initiatives

The Latrobe Health Innovation Zone, Latrobe Health Assembly and Latrobe Health Advocate have been tasked with the overall objective of improving health and wellbeing in Latrobe.

The relationship between the initiatives is depicted below. While these initiatives appear as if they are operating in parallel, in practice their functions are highly interrelated.

Overarching objective: Improving health and wellbeing in Latrobe

Latrobe Health Innovation Zone
A Charter for the Zone is being developed by Federation University

Latrobe Health Assembly

Latrobe Health Advocate

Feedback to and from the evaluation will be provided on an ongoing basis:

Impact area 1 (IA1): Improved community opportunities and perception
Impact area 2 (IA2): Improved community connectedness and participation
Impact area 3 (IA3): Improved health service access and design
Impact area 4 (IA4): Improved health and lifestyle

Other initiatives and programs in Latrobe Valley
As defined in section 1

Other external factors, such as economic conditions
Latrobe Health Innovation Zone evaluation model

This evaluation model is indicative only and will require review following the finalisation of the Charter for the Zone by Federation University

**Overarching objective:** Improving health and wellbeing in Latrobe

<table>
<thead>
<tr>
<th>Impact areas</th>
<th>Short term outcomes (year 0-1)</th>
<th>Medium term outcomes (year 2-3)</th>
<th>Long term outcomes (year 4-5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(IA1) Improved community opportunities and perception</td>
<td>(SO1) Sectors within Latrobe are aware the region is a designated Zone, including sectors not traditionally associated with health such as small business and education</td>
<td>(MO1) New ways of working improve opportunities available in the Zone</td>
<td>(LO1) New ways of working lead people external to the community to view Latrobe as a healthy city</td>
</tr>
<tr>
<td>(IA2) Improved community connectedness and participation</td>
<td>(SO2) Sectors work together in new ways to improve opportunities available in the Zone</td>
<td>(MO2) New ways of working are embedded in sector organisations</td>
<td></td>
</tr>
<tr>
<td>(IA3) Improved health service access and design</td>
<td>(SO3) The community are aware of and understand the purpose of the Zone</td>
<td>(MO3) Increased community participation leads to improved social connections</td>
<td>(LO2) The community has improved capacity to develop and implement community programs</td>
</tr>
<tr>
<td>(IA4) Improved health and lifestyle</td>
<td>(SO4) The community feel ownership of the charter for the Zone</td>
<td>(MO4) The community lead programs for the Zone</td>
<td>(LO3) The community has improved resilience</td>
</tr>
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<td></td>
<td>(SO5) The community participate in programs for the Zone</td>
<td></td>
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<tr>
<td></td>
<td>(SO6) The Zone is a focal point for the coordination and integration of health and wellbeing services, including service providers not traditionally associated with health such as employment, education and justice</td>
<td>(MO5) &quot;No wrong door&quot; – The community are put in touch with the service they need regardless of who they contact first</td>
<td>(LO4) New ways of working attract health and wellbeing professionals to the Zone</td>
</tr>
<tr>
<td></td>
<td>(SO7) Local service providers invest in new ways of working together to improve service integration in the Zone</td>
<td>(MO6) New ways of working are embedded in service providers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(SO8) The community are aware they are in the Zone when making choices related to their health and wellbeing</td>
<td>(MO7) The community make positive changes to their health and wellbeing behaviours</td>
<td>(LO5) The community has a culture of healthy living</td>
</tr>
<tr>
<td></td>
<td>(SO9) The community has improved access to healthy options including healthy food and physical activity options</td>
<td>(MO8) The community encourage their friends and family to make positive changes to their health and wellbeing behaviours</td>
<td>(LO6) The community has improved health outcomes including reduced chronic disease and mental health</td>
</tr>
<tr>
<td></td>
<td>(SO10) The community has improved access to healthy social environments and activities</td>
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</tr>
</tbody>
</table>

**Inputs:**
- The community
- The Assembly
- The Advocate
- DHHS
- Key health and wellbeing related organisations in Latrobe, many of whom are on the Board of the Assembly
- Organisations from other sectors

**Activities:**
- The activities of the Zone are dependent on what the above groups choose to do

**Outputs:**
- Number of innovative approaches/ ways of working developed
Latrobe Health Assembly evaluation model
This evaluation model is indicative only and will require consideration by the Assembly, this is expected to occur at the November 2017 meeting

**Overarching objective: Improving health and wellbeing in Latrobe**

<table>
<thead>
<tr>
<th>Impact areas</th>
<th>Short term outcomes (year 0-1)</th>
<th>Medium term outcomes (year 2-3)</th>
<th>Long term outcomes (year 4-5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(IA1) Improved community opportunities and perception</td>
<td>(SO11) Sectors within Latrobe are influenced to improve local opportunities due to strong relationships between Assembly members and sector leaders including sectors not traditionally associated with health such as small business and education</td>
<td>(MO9) The community has improved access to opportunities</td>
<td>(LO7) Improved opportunities lead people external to the community to view Latrobe as a healthy city</td>
</tr>
<tr>
<td>(IA2) Improved community connectedness and participation</td>
<td>(SO12) Sectors plan, develop and implement programs to improve local opportunities</td>
<td>(MO10) Programs are community-led with support from the Assembly where required</td>
<td>(LO8) The community has improved capacity to act in a protective manner to prevent issues from becoming acute</td>
</tr>
<tr>
<td>(IA3) Improved health service access and design</td>
<td>(SO13) The community are aware of the Assembly and understands their role</td>
<td>(MO11) The community feel trusted and empowered to lead community programs</td>
<td>(LO9) The community are confident that they, their family and their friends can access the health and wellbeing services they need, when they need them</td>
</tr>
<tr>
<td>(IA4) Improved health and lifestyle</td>
<td>(SO14) The community are supported to plan, develop and implement programs</td>
<td>(MO12) The community has improved access to local, culturally appropriate, specialist services for chronic disease, mental health, alcohol and other drugs, and preventive health</td>
<td>(LO10) The community has improved health outcomes including reduced chronic disease and mental health</td>
</tr>
</tbody>
</table>

**Inputs:**
- Existing health and wellbeing data/evidence
- Self-monitoring/evaluation outcomes
- Assembly office staff

**Activities:**
- Drives innovation across the Zone
- Engages with the community
- Brings the community, service providers and other sectors together
- Oversees the development of local partnerships
- Promotes consistency in prevention and planning

**Outputs:**
- Number of Assembly meetings held
- Number of Assembly Board meetings held
- Number of Assembly working group meetings held
- Number of Project Initiation Documents (PIDs) developed
- Number of Business Cases developed and taken to the Board
- Number of pilots initiated
- Number of projects expanded
- Number of processes developed to facilitate a culture of learning and continuous improvement

**Line of accountability**

| LO7 | Improved opportunities lead people external to the community to view Latrobe as a healthy city |
| LO8 | The community has improved capacity to act in a protective manner to prevent issues from becoming acute |
| LO9 | The community are confident that they, their family and their friends can access the health and wellbeing services they need, when they need them |
| LO10 | The community has improved health outcomes including reduced chronic disease and mental health |

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Latrobe Health Advocate evaluation model
This evaluation model is indicative only and will require consideration by the Advocate, once appointed

Overarching objective: Improving health and wellbeing in Latrobe

<table>
<thead>
<tr>
<th>Impact areas</th>
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<th>Medium term outcomes (year 2-3)</th>
<th>Long term outcomes (year 4-5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(IA1) Improved</td>
<td>(SO20) Latrobe and the community’s needs are better represented to the Government due to strong relationships between the Advocate and key government stakeholders</td>
<td>(MO19) Policy decisions reflect that the Government understands the positives of Latrobe and the community’s needs are better represented to the Government due to strong relationships between the Advocate and key government stakeholders</td>
<td>(LO11) The community has improved confidence in the Government’s ability to understand the positives of Latrobe and the community’s needs are better represented to the Government due to strong relationships between the Advocate and key government stakeholders</td>
</tr>
<tr>
<td>Community opportunities and perception</td>
<td>(SO21) The community are aware of and understand the role of the Advocate</td>
<td>(MO21) The community’s concerns are addressed more effectively</td>
<td>(LO12) The community has greater capacity to advocate for their health and wellbeing needs</td>
</tr>
<tr>
<td>(IA2) Improved community connectedness and participation</td>
<td>(SO22) The community feel heard, respected and understood by the Advocate</td>
<td>(MO22) The community feel empowered and enabled to advocate for their health and wellbeing</td>
<td></td>
</tr>
<tr>
<td>(IA3) Improved health service access and design</td>
<td>(SO23) The community have confidence in the Advocate’s ability to represent their needs</td>
<td>(MO23) The community has improved access to affordable services</td>
<td>(LO13) The community are confident that they, their family and their friends can access the health and wellbeing services they need, when they need them and at an affordable cost</td>
</tr>
<tr>
<td>(IA4) Improved health and lifestyle</td>
<td>(SO24) The Advocate is a respected representative of the community in health and wellbeing service planning at a local and State level</td>
<td>(MO24) The community has improved access to local, culturally appropriate, specialist services for chronic disease, mental health, alcohol and other drugs, and preventive health</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(SO25) The community’s health and wellbeing needs are communicated</td>
<td>(MO25) “No wrong door” – The community are put in touch with the service they need regardless of who they contact first</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(SO26) The Advocate is a focal point for health and wellbeing leadership within the community</td>
<td>(MO26) The community feel empowered to make positive changes to their health and wellbeing behaviours</td>
<td>(LO14) The community has a culture of healthy living</td>
</tr>
</tbody>
</table>

Inputs:
- Existing health and wellbeing data/evidence

Activities:
- Has strong relationships with policy and decision makers at the local and State level
- Advocates to government to ensure local opportunities and services meet the community’s needs
- Engages with the community regarding their health and wellbeing needs
- Involves the community in advocating for the positives of the region

Outputs:
- Number of meetings with government and other stakeholders
- Number of policies and other key decisions influenced
3. Evaluation questions
Evaluation questions define the scope and focus of the evaluation. Toward the beginning, the evaluation will have a greater focus on process evaluation questions. Overtime, this focus will shift more towards outcome evaluation questions.

The evaluation questions detailed in this document have been categorised according to the following:

- **Domain:**
  - **Appropriateness:** These questions will look at the design of the Latrobe health initiatives relative to their intended objectives and outcomes.
  - **Effectiveness:** These questions will look at the extent to which the Latrobe health initiatives are meeting, or are on track to meeting, their defined outcomes.
  - **Sustainability:** These questions explore the ability of the Latrobe health initiatives to be maintained over-time.

- **Type:**
  - **Process:** These questions will look at the processes undertaken during the planning and implementation of the Latrobe health initiatives.
  - **Development:** These questions will look at the early stages of the Latrobe health initiatives and how they are tracking towards achieving their outcomes.
  - **Outcome:** These questions will look at the outcomes achieved by the Latrobe health initiatives.

In section 5, evaluation questions are mapped to outcomes and data sources. Evaluation questions relating to appropriateness have not been mapped to outcomes as they relate to the design of the initiatives. These questions need to consider both the extent to which the initiatives operated in an innovative manner, in addition to the extent to which the initiatives leveraged the existing evidence-base.

While there is sometimes a perceived tension between innovative and evidence-based initiatives, this does not always need to be the case. This is because initiatives that are intended to be innovative are at risk of repeating the mistakes of the past if they fail to learn from what has been tried before and use this as a platform from which they can drive innovation.
# Evaluation questions

Initiative refers to the Latrobe Health Innovation Zone, Latrobe Health Assembly and the Latrobe Health Advocate interchangeably, please refer to section 5 for detail regarding the data sources for each question.

<table>
<thead>
<tr>
<th>ID</th>
<th>Type</th>
<th>Domain</th>
<th>Question</th>
<th>Sub-question</th>
</tr>
</thead>
<tbody>
<tr>
<td>EQ1</td>
<td>Process</td>
<td>Appropriateness</td>
<td>How is the initiative employing innovating ways of improving health and wellbeing via a community-led approach?</td>
<td>How is the initiative focusing on new, original and creative approaches?</td>
</tr>
<tr>
<td>EQ2</td>
<td>Process</td>
<td>Appropriateness</td>
<td>How is the initiative informed by the existing evidence-base for improving health and wellbeing via a community-led approach?</td>
<td>How is the initiative learning from previous community-led health and wellbeing approaches, either in Latrobe or elsewhere? How is the initiative learning from its own approaches?</td>
</tr>
<tr>
<td>EQ3</td>
<td>Process</td>
<td>Appropriateness</td>
<td>How appropriate is the initiative for improving health and wellbeing in Latrobe via a community-led approach?</td>
<td>What was the rationale for establishing the initiative? Was this clear?</td>
</tr>
<tr>
<td>EQ4</td>
<td>Development</td>
<td>Effectiveness</td>
<td>What is going well? Why?</td>
<td>What was it about a process that lead to it working? What &quot;quick wins&quot; or early cases of success has the initiative experienced? Are there early signs that the initiative is on track to achieving its objectives? Is there a perceived or measurable cause for this? How might these be enhanced? Can what worked be replicated?</td>
</tr>
<tr>
<td>EQ5</td>
<td>Development</td>
<td>Effectiveness</td>
<td>What is not going well? Why?</td>
<td>What blockers or challenges is the initiative facing? Is there a perceived or measurable cause for this? How might these be addressed?</td>
</tr>
<tr>
<td>EQ6</td>
<td>Development</td>
<td>Effectiveness</td>
<td>What processes could be improved, why and how?</td>
<td>What governance processes could be improved? What design processes could be improved? What targeting processes could be improved? What awareness processes could be improved? What engagement/collaboration processes could be improved?</td>
</tr>
<tr>
<td>EQ7</td>
<td>Development</td>
<td>Effectiveness</td>
<td>Do community members have a sufficient level of awareness and understanding of the initiative?</td>
<td>What community engagement and communication has been performed to date? Are community members aware of the initiative, understand its purpose and feel engaged and empowered to influence it?</td>
</tr>
</tbody>
</table>

*Initiative refers to the Latrobe Health Innovation Zone, Latrobe Health Assembly and the Latrobe Health Advocate interchangeably.*
# Evaluation questions

Initiative refers to the Latrobe Health Innovation Zone, Latrobe Health Assembly and the Latrobe Health Advocate interchangeably, please refer to section 5 for detail regarding the data sources for each question.

<table>
<thead>
<tr>
<th>ID</th>
<th>Type</th>
<th>Domain</th>
<th>Question</th>
<th>Sub-question</th>
</tr>
</thead>
</table>
| EQ8 | Development | Effectiveness   | How are community members involved in the initiative?                                                   | Do community members feel sufficiently consulted or otherwise involved in constructing the initiative's purpose, objectives and programs?  
Do community members feel there is sufficient opportunity for them to participate in these programs?  
Are community members participating in these programs?  
Is this community involvement representative?  
Are hard to reach groups participating? |
| EQ9 | Development | Effectiveness   | Is the pace of change effected by the initiative in line with expected outcome timeframes?            | Are the anticipated effect of the programs established or influenced aligned with the initiative's intended outcomes?  
How is the initiative managing the balance between representative community consultation and delivery?  
Do community members feel the initiative is establishing or influencing programs with sufficient effect and at a reasonable pace? |
| EQ10 | Outcome   | Effectiveness   | How effective was the initiative in working collaboratively to contribute to improved health and wellbeing in Latrobe? | How did the initiative contribute towards the anticipated outcomes?  
Were there any unexpected consequences of the initiative? Either positive, neutral or negative. What factors influenced these?  
Were the consequences of the initiative equally distributed amongst the community? If not, can this variation be reasonable explained?  
What lessons can be drawn from the community engagement and communication process to inform future community-led work?  
What would have been the impact if this initiative was not delivered or had prematurely ended? |
### Evaluation questions

Initiative refers to the Latrobe Health Innovation Zone, Latrobe Health Assembly and the Latrobe Health Advocate interchangeably, please refer to section 5 for detail regarding the data sources for each question.

<table>
<thead>
<tr>
<th>ID</th>
<th>Type</th>
<th>Domain</th>
<th>Question</th>
<th>Sub-question</th>
</tr>
</thead>
<tbody>
<tr>
<td>EQ11</td>
<td>Outcome</td>
<td>Effectiveness</td>
<td>How effective was the initiative in meeting community needs?</td>
<td>How were community needs identified? Were these needs met? To what extent were community needs met? What factors influenced this?</td>
</tr>
<tr>
<td>EQ12</td>
<td>Outcome</td>
<td>Effectiveness</td>
<td>How effective was the initiative in improving health and wellbeing in Latrobe?</td>
<td>How well was the initiative adaptively managed to provide accountability for high level objectives while remaining flexible and responsive to community-led activity? Did the initiative meet its objectives within the allocated budget and timeframe?</td>
</tr>
<tr>
<td>EQ13</td>
<td>Outcome</td>
<td>Sustainability</td>
<td>Is there evidence of the initiative's ongoing sustainability?</td>
<td>Do community members feel there is a need for the initiative to continue? Are community members entrenched in the management and delivery of the initiative? Given the observed or measurable effect of the initiative, what are the ethical considerations of deciding whether or not to continue the initiative?</td>
</tr>
<tr>
<td>EQ14</td>
<td>Outcome</td>
<td>Sustainability</td>
<td>How could the initiative be re-scoped or otherwise enhanced?</td>
<td>What aspects of the initiative appear to have supported success?</td>
</tr>
</tbody>
</table>

*Initiative refers to the Latrobe Health Innovation Zone, Latrobe Health Assembly and the Latrobe Health Advocate interchangeably.*
4. Data requirements and approach
Data approach

Qualitative and quantitative data will be drawn from primary and secondary sources, and triangulated to inform the evaluation.

The Latrobe Health Innovation Zone, Latrobe Health Assembly and Latrobe Health Advocate have been tasked with improving health and wellbeing in Latrobe. These initiatives are expected to both represent and lead to positive change. Given the broad scope of health and wellbeing and as the evaluation will consider a range of indicators and data; both primary and secondary.

The below diagram represents the relationships that exist between the data types that will be drawn on throughout the evaluation. The naming of these data types relates to how the data is collected and bears no relation to their level of importance.

**Primary data**
- Data that is collected for the purposes of this evaluation, by the evaluation team.
  - Initiative data
  - Facebook
  - Other media
  - Broad surveying
  - Workshops
  - Existing meetings and events
  - Interviews
  - Targeted surveying (as required)
  - “Going to where the community are” (as required).

**Secondary data**
- Data that was collected by people other than the evaluation team.
  - Literature review
  - Victorian Population Health Survey (VPHS)
  - VicHealth Indicators Survey
  - Local Government Area (LGA) Statistical Profiles
  - Avoidable Mortality (AM)
  - Ambulatory Care Sensitive Conditions (ACSC)
  - MBS Online
  - Preventive Health Survey (PHS)
  - Hazelwood Health Study
  - Other evaluations.

**Data triangulation (brining it all together)**
- The evaluation will commence with the compilation of a database of the current state of health and wellbeing in Latrobe. This will be brought together with qualitative data as the evaluation progresses.
Primary data collection approach

Primary data will be guided by the evaluation model impact areas described in section 2:

- (IA1) Improved community opportunities and perception
- (IA2) Improved community connectedness and participation
- (IA3) Improved health service access and design
- (IA4) Improved health and lifestyle.

While the primary data collection will be loosely structured around these impact areas, it is important to note that these simply represent a suggested priority for discussion and that conversations will likely span all impact areas and initiatives. However, for certain stakeholder conversations it may be more appropriate to have a greater focus one impact area. For example, when speaking with stakeholders from the Latrobe Regional Hospital, and other health service providers, it would make sense to focus the majority of our conversation on the extent to which the initiatives are contributing to ‘improved health service access and design’.

A more detailed stakeholder communications and engagement plan exists as a separate document. The stakeholder communications and engagement plan was drafted following early insights obtained from our preliminary stakeholder conversations in phase 1 of our approach. These conversations were held with a variety of stakeholders including people from the Latrobe City Council, Latrobe Community Health Service, Latrobe Regional Hospital, Gippsland Primary Health Network, Latrobe Valley Authority and the Hazelwood Health Study.

The following pages contain the high level approach to primary data collection throughout the evaluation. Throughout the approach, references are made to “hard to reach groups”. In the context of this evaluation, “hard to reach groups” have been defined as Latrobe community members who would not usually choose to participate in broad consultation methods such as surveys or workshops. These community members may include recently arrived migrants, people who are linguistically or culturally diverse, people with a disability and carers.
Primary data collection approach over the next 6 months
These dates are indicative only and are subject to stakeholder availability. This approach will be revised towards the end of this 6 months in preparation for the remainder of the evaluation

While the diagram below represents the impact areas and initiatives independently, it is important to note that these simply represent a suggested priority for discussion and that our conversations will likely span all initiatives and impact areas. However, for certain stakeholder groups it may be more appropriate to have a greater focus one impact area.

To schedule these meetings, the evaluation will go back to every stakeholder group consulted in the design of the evaluation framework to advise of the evaluation’s commencement and to invite them to participate. As such, the exact timing and method of these engagements is to be confirmed and will depend upon the responses received.

Regular, informal feedback will be provided to assist in improving these initiatives as they occur, and actively including the community and people who are part of the initiatives in this process. This will mean that people can see how the information they have provided is being used and that the feedback provided by the evaluation contains no surprises.

<table>
<thead>
<tr>
<th>Impact area</th>
<th>Consultation method</th>
<th>Latrobe Health Innovation Zone</th>
<th>Latrobe Health Assembly</th>
<th>Latrobe Health Advocate</th>
</tr>
</thead>
<tbody>
<tr>
<td>(IA1) Improved community opportunities and perception*</td>
<td>Workshops and forums</td>
<td>Week commencing 30-Apr</td>
<td>Week commencing 05-Feb</td>
<td>Week commencing 30-Apr</td>
</tr>
<tr>
<td>(IA2) Improved community connectedness and participation</td>
<td>Existing meetings and events</td>
<td>Week commencing 14-May</td>
<td>Week commencing 19-Feb</td>
<td>Week commencing 19-Mar</td>
</tr>
<tr>
<td>(IA3) Improved health service access and design</td>
<td>Interviews</td>
<td>Week commencing 28-May</td>
<td>Week commencing 05-Feb</td>
<td>Week commencing 19-Mar</td>
</tr>
<tr>
<td>(IA4) Improved health and lifestyle</td>
<td>Workshops and forums</td>
<td></td>
<td>Week commencing 05-Mar</td>
<td>Week commencing 02-Apr</td>
</tr>
</tbody>
</table>

*This consultation stream will be integrated with other streams where appropriate.
Primary data collection strategies
Primary data will be collected using a range of engagement strategies, tailored to each stakeholder group

<table>
<thead>
<tr>
<th>Stakeholder groups:</th>
<th>Media:</th>
<th>Other media (e.g. Newspapers, radio, other social media)</th>
<th>Broad consultation:</th>
<th>Workshops and forums</th>
<th>Existing meetings and events</th>
<th>Semi-structured interviews</th>
<th>Targeted consultation (as required):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broader community</td>
<td>Facebook</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️, ✔️</td>
</tr>
<tr>
<td>Hard to reach community</td>
<td></td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️, ✔️</td>
</tr>
<tr>
<td>Aboriginal community</td>
<td></td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️, ✔️</td>
</tr>
<tr>
<td>Community representative groups</td>
<td></td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️, ✔️</td>
</tr>
<tr>
<td>Local government and funded organisations</td>
<td></td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️, ✔️</td>
</tr>
<tr>
<td>Government and agencies</td>
<td></td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️, ✔️</td>
</tr>
<tr>
<td>Committees and governance</td>
<td></td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️, ✔️</td>
</tr>
</tbody>
</table>

Key: ✔️ Priority strategy, ✔️ Supplementary strategy

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Primary data collection strategies
Primary data will be collected using a range of engagement strategies, tailored to each stakeholder group

<table>
<thead>
<tr>
<th>Initiative data</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document review</td>
<td>Documents produced by the initiatives including Project Initiation Documents (PIDs), business cases, project evaluations, and communication and engagement strategies. This is not an exhaustive list.</td>
</tr>
<tr>
<td>Initiative generated data</td>
<td>Data generated by the Assembly and Advocate over-time.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Media</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facebook</td>
<td>A key insight from our preliminary stakeholder engagements was that Facebook is the most appropriate social media platform for providing information and opportunities for comment involving the broadest range of Latrobe community members. The Latrobe Health Innovation Zone Evaluation Facebook page was established in September 2017. This Facebook page will continue to be used throughout the evaluation to share information with the Latrobe community regarding future opportunities for participation and ongoing feedback from the evaluation in an iterative manner.</td>
</tr>
</tbody>
</table>

| Other media | Additional media sources such as newspapers and radio will continue to be used to broaden our communications reach. Including advertisements in the in the Latrobe Valley Express. The evaluation will also consider other social media platforms. |

<table>
<thead>
<tr>
<th>Broad consultation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broad surveying</td>
<td>A community survey will be launched shortly after the commencement of the evaluation to facilitate ongoing collection of quantitative and qualitative data relating to health and wellbeing in Latrobe, and feedback on the Latrobe health initiatives. The evaluation will continue to leverage the Facebook page and existing relationships to promote the survey. Surveys allow for high-volume, qualitative and quantitative data to be captured. They will also allow the community and other stakeholders to provide input to the evaluation in their own time, at their own pace and in a removed manner that may encourage greater forthrightness. Posters advertising the survey could be posted in local shopping centres, primary schools, libraries, neighbourhood houses, healthcare centres and places where parents wait while their children participate in an activity. These posters could display a QR code which community members could scan using their mobile phone to be taken to the online survey website directly. Refer to appendix C for an example broad community survey.</td>
</tr>
</tbody>
</table>

| Workshops and forums | Workshops will be used to engage with the Latrobe community to understand what the attendees would like these initiatives to contribute to Latrobe and whether they are on track to achieving these outcomes. It is anticipated that one workshop on each impact area in each of the four main Latrobe towns will be required. It is essential that the intent of workshops is clearly framed so as to avoid misrepresentation to the community and false expectations in terms of what the evaluation, and their participation in the evaluation, is likely to achieve. Workshops and forums could be live streamed via the Facebook page. |
Primary data collection strategies
Primary data will be collected using a range of engagement strategies, tailored to each stakeholder group

<table>
<thead>
<tr>
<th>Direct consultation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Existing meetings and events</td>
<td>The evaluation will seek to leverage existing meetings and events where possible. The time allocated to the evaluation would be used to understand what the attendees would like these initiatives to contribute to Latrobe in and whether they are on track to achieving these outcomes. To schedule these meetings, the evaluation will go back to every stakeholder group consulted in the design of the evaluation framework to advise of the commencement of the evaluation and to invite them to participate. As such, the exact timing and method of these engagements is to be confirmed and will depend upon the responses received.</td>
</tr>
<tr>
<td>Semi-structured interviews</td>
<td>Semi-structured interviews will be held with stakeholders to obtain specific feedback on whether these initiatives are on track to achieving their stated objects in the context of the nominated consultation stream. Stakeholders consulted in this manner may include people on or connected with the Assembly, community representative groups, local government and funded organisations, government and agencies, and committees and governance. These interviews will be held at times that suit the participant. A guide will be provided to participants prior to each interview to provide information about the project and topics for discussion. Refer to appendix D for an example semi-structured interview guide.</td>
</tr>
</tbody>
</table>

As required
The evaluation may decide to concentrate on a specific sub-community within Latrobe requiring targeted data collection. In the event of this, the evaluation will decide upon the most appropriate manner of obtaining this information. This may be through targeted consultation. Two examples of targeted consultation are listed below. This may occur where a program of the Zone, Assembly or Advocate is being targeted at a specific group within the community and the evaluation chooses to focus on this area.

<table>
<thead>
<tr>
<th>Targeted consultation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Targeted surveying</td>
<td>For hard to reach groups: Targeted surveys could be administered via paper-based survey questionnaires that could be distributed by mail or in person. If administered in person, this could include trained community members undertaking community based visits (see below). For Assembly members: The evaluation will also explore the option with the Assembly of a self-reflection survey for working group members to complete following the pilot and project completion phases of any programs they deliver. This would be to ascertain their thoughts on what went well, what could be improved, and key influences.</td>
</tr>
<tr>
<td>Community based visits</td>
<td>A recurrent theme emerging from our preliminary stakeholder engagements has been the importance of going to places that community members frequent and engaging with them on their own terms. This has frequently been highlighted as a successful means of obtaining both a breadth and depth of community participation. This may include local shopping centres, primary schools, libraries, neighbourhood houses, healthcare centres and places where parents wait while their children participate in an activity. This method was used in the development of the Latrobe City Council Municipal Public Health and Wellbeing Plan 2017-2021.</td>
</tr>
</tbody>
</table>
Secondary data collection approach
Secondary data will be collected from a range of data sources available at the Latrobe LGA level

The evaluation will commence with a detailed literature review and the compilation of a database relating to the current state of health and wellbeing in Latrobe. This will be added to and monitored as the evaluation, and the initiatives, progress.

Combining changes in these indicators and trends with other qualitative data will assist in providing insights on the areas where the Zone, Assembly or Advocate are collectively and individually seeking to have an impact. These insights will be reported at an initiative level (i.e. the Zone, the Assembly and/or the Advocate), however, a more detailed deep dive may be undertaken to highlight changes in factors that contribute to health and wellbeing.

<table>
<thead>
<tr>
<th>Secondary data source</th>
<th>Description</th>
<th>Collection frequency</th>
<th>Collection level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Literature review</td>
<td>The evaluation will commence with a detailed literature review including (but not limited to) the following topics: local and international examples of similar initiatives (extending beyond the scope of the targeted review included in this document), engaging and empowering the community to participate in public health improvement approaches, health innovation, health advocacy and participatory democracy.</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Victorian Population Health Survey (VPHS)</td>
<td>A Victorian survey which collects information on overall self-rated health status, level of psychological distress, body mass index, the presence of chronic diseases, nutrition, physical activity, smoking and alcohol consumption. Information is also collected on participation in screening for bowel cancer, cervical cancer, breast cancer, high blood pressure, cholesterol and high blood sugar in addition to community participation, levels of social support and connections with others. Interviews are conducted in the major non-English languages in Victoria to ensure people of culturally and linguistically diverse backgrounds are represented.</td>
<td>Every 3 years, the next collection is 2017 (funding permitting)</td>
<td>Latrobe LGA</td>
</tr>
<tr>
<td>VicHealth Indicators Survey</td>
<td>A Victorian community wellbeing survey which focuses on the social determinants of health. The survey is based on core questions related to individual and community health and wellbeing, critical to inform decisions about public health priorities.</td>
<td>Every 4 years</td>
<td>Latrobe LGA</td>
</tr>
<tr>
<td>Local Government Area (LGA) Statistical Profiles</td>
<td>Profiles developed by DHHS on an annual basis to support and inform health and human service planning and policy development. The profiles provide measures on a broad range of topics including: population, diversity, disadvantage and social engagement, housing, transport and education, health status and service utilisation, child and family characteristics and service utilisation.</td>
<td>Variable, dependent on underlying data sources</td>
<td>Latrobe LGA</td>
</tr>
</tbody>
</table>
Secondary data will be collected from a range of data sources available at the Latrobe LGA level

<table>
<thead>
<tr>
<th>Secondary data source</th>
<th>Description</th>
<th>Collection frequency</th>
<th>Collection level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoidable Mortality (AM)</td>
<td>A method of counting untimely and unnecessary deaths from diseases for which effective public health and medical interventions are available. An excess of deaths due to preventable causes should suggest shortcomings in the healthcare system that warrant further attention.</td>
<td>Annually</td>
<td>Latrobe LGA</td>
</tr>
<tr>
<td>Ambulatory Care Sensitive Conditions (ACSC)</td>
<td>Describes hospitalisation rates for which hospitalisation is thought to be avoidable with the application of public health interventions and early disease management, usually delivered in an ambulatory setting such as primary care. High rates of hospital admissions for ACSCs may provide indirect evidence of problems with patient access to primary healthcare, inadequate skills and resources, or disconnection with specialist services.</td>
<td>Annually</td>
<td>Latrobe LGA</td>
</tr>
<tr>
<td>MBS Online</td>
<td>Lists the availability and utilisation of services the Medicare services subsidised by the Australian government (i.e. services listed on the Medicare Benefits Schedule (MBS)).</td>
<td>Annually</td>
<td>Latrobe LGA</td>
</tr>
</tbody>
</table>

It is expected that the following data sources will also be used, however, at present it is unclear what indicators will be available over-time

<table>
<thead>
<tr>
<th>Secondary data source</th>
<th>Description</th>
<th>Collection frequency</th>
<th>Collection level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Health Survey (PHS)</td>
<td>Conducted by DHHS from October 2016 to June 2017. A Victorian survey which looks at how people's attitudes, beliefs, social norms and understanding of health issues help to determine their health and lifestyle behaviours including tobacco consumption, fruit and vegetable intake, physical activity and weight.</td>
<td>Unknown</td>
<td>Unknown, expect at the Latrobe LGA level</td>
</tr>
<tr>
<td>Hazelwood Health Study</td>
<td>The Hazelwood Health Study is about identifying potential health outcomes for people who may have been impacted by the smoke from the mine fire. These might include heart and lung disease, cancer or mental health problems. It will also look at the effects on vulnerable groups such as infants and children, young people, and other people.</td>
<td>Variable</td>
<td>Variable</td>
</tr>
<tr>
<td>Other evaluations</td>
<td>There are many parallel programs of work in Latrobe. Many of these will have an impact on the health and wellbeing of the Latrobe community. Evaluations may be conducted for these programs, the information collected as part of these evaluations may be relevant as part of this evaluation. For example, the evaluation of the deliverables 69-77 relating to early detection and screening including smoking cessation contracted to the GPHN, the evaluation of the Latrobe Health Innovation Zone mental health and chronic disease pilots.</td>
<td>Variable</td>
<td>Unknown, expect at a smaller level than Latrobe LGA</td>
</tr>
</tbody>
</table>
## Evaluation questions

Initiative refers to the Latrobe Health Innovation Zone, Latrobe Health Assembly and the Latrobe Health Advocate interchangeably, please refer to section 5 for detail regarding the data sources for each question.

<table>
<thead>
<tr>
<th>ID</th>
<th>Question</th>
<th>Sub-question</th>
<th>Data source</th>
</tr>
</thead>
</table>
| EQ1| How is the initiative employing innovating ways of improving health and wellbeing via a community-led approach? | How is the initiative focussing on new, original and creative approaches? | Primary:  
Surveys of: Assembly members and working groups, the Advocate  
Existing meetings of: Assembly members and working groups  
Interviews with: the Advocate  
Document review: PIDs, business cases |
|    |                                                                          | How is the initiative learning from previous community-led health and wellbeing approaches, either in Latrobe or elsewhere? | Primary:  
Surveys of: community members and groups, Assembly members and working groups, the Advocate  
Existing meetings and events of: Assembly working group members, the Advocate  
Document review: PIDs, business cases |
|    |                                                                          | How is the initiative learning from its own approaches?                        | Secondary: literature reviews                                               |
| EQ2| How is the initiative informed by the existing evidence-base for improving health and wellbeing via a community-led approach? |                                                                              |                                                                              |
|    |                                                                          |                                                                              |                                                                              |
| EQ3| How appropriate is the initiative for improving health and wellbeing in Latrobe via a community-led approach? | What was the rationale for establishing the initiative?  
Was this clear? | Primary:  
Surveys of: community members and groups, Assembly members and working groups, the Advocate  
Existing meetings and events of: Assembly working group members, the Advocate  
Document review: PIDs, business cases  
Secondary: literature reviews |
## Evaluation questions

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</thead>
</table>
| EQ4 | What is going well? Why? | What was it about a process that lead to it working?  
What "quick wins" or early cases of success has the initiative experienced?  
Are there early signs that the initiative is on track to achieving its objectives?  
Is there a perceived or measurable cause for this?  
How might these be enhanced?  
Can what worked be replicated? | Primary:  
Surveys of: community members and groups, Assembly members and working groups, the Advocate, local government and funded organisations, government and agencies  
Workshops with: community members and groups  
Existing meetings and events of: community members and groups, the Assembly and working groups, the Advocate, local government and funded organisations, government and agencies  
Interviews with: the Advocate  
Document review: PIDs, business cases |
| EQ5 | What is not going well? Why? | What blockers or challenges is the initiative facing?  
Is there a perceived or measurable cause for this?  
How might these be addressed? | Primary:  
Surveys of: community members and groups, Assembly members and working groups, the Advocate, local government and funded organisations, government and agencies  
Workshops with: community members and groups  
Existing meetings and events of: community members and groups, the Assembly and working groups, the Advocate, local government and funded organisations, government and agencies  
Interviews with: the Advocate  
Document review: PIDs, business cases |
| EQ6 | What processes could be improved, why and how? | What governance processes could be improved?  
What design processes could be improved?  
What targeting processes could be improved?  
What awareness processes could be improved?  
What engagement/collaboration processes could be improved? | Primary:  
Surveys of: community members and groups, Assembly members and working groups, the Advocate, local government and funded organisations, government and agencies  
Workshops with: community members and groups  
Existing meetings and events of: community members and groups, the Assembly and working groups, the Advocate, local government and funded organisations, government and agencies  
Interviews with: the Advocate  
Document review: PIDs, business cases |
## Evaluation questions

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<tbody>
<tr>
<td>EQ7</td>
<td>Do community members have a sufficient level of awareness and understanding of the initiative?</td>
<td>What community engagement and communication has been performed to date? Are community members aware of the initiative, understand its purpose and feel engaged and empowered to influence it?</td>
<td>Primary: Surveys of: community members and groups, Assembly members and working groups, the Advocate Workshops with: community members and groups Existing meetings and events of: community members and groups, the Assembly and working groups Interviews with: the Advocate Document review: communication and engagement strategy review</td>
</tr>
<tr>
<td>EQ8</td>
<td>How are community members involved in the initiative?</td>
<td>Do community members feel sufficiently consulted or otherwise involved in constructing the initiative's purpose, objectives and programs? Do community members feel there is sufficient opportunity for them to participate in these programs? Are community members participating in these programs? Is this community involvement representative? Are hard to reach groups participating?</td>
<td>Primary: Surveys of: community members and groups, Assembly members and working groups, the Advocate Workshops with: community members and groups Existing meetings and events of: community members and groups, the Assembly and working groups Interviews with: the Advocate Document review: communication and engagement strategy review</td>
</tr>
<tr>
<td>EQ9</td>
<td>Is the pace of change effected by the initiative in line with expected outcome timeframes?</td>
<td>Are the anticipated effect of the programs established or influenced aligned with the initiative's intended outcomes? How is the initiative managing the balance between representative community consultation and delivery? Do community members feel the initiative is establishing or influencing programs with sufficient effect and at a reasonable pace?</td>
<td>Primary: Surveys of: community members and groups, Assembly members and working groups, the Advocate, local government and funded organisations, government and agencies Workshops with: community members and groups Existing meetings and events of: community members and groups, the Assembly and working groups Interviews with: the Advocate Document review: PIDs, business cases</td>
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## Evaluation questions

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### EQ10

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</tr>
</thead>
<tbody>
<tr>
<td>EQ10</td>
<td>How effective was the initiative in working collaboratively to contribute to improved health and wellbeing in Latrobe?</td>
<td>How did the initiative contribute towards the anticipated outcomes?</td>
<td>Primary: Surveys of: community members and groups, Assembly members and working groups, the Advocate Workshops with: community members and groups Existing meetings and events of: community members and groups, the Assembly and working groups Interviews with: the Advocate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Were there any unexpected consequences of the initiative? Either positive, neutral or negative. What factors influenced these?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Were the consequences of the initiative equally distributed amongst the community? If not, can this variation be reasonable explained?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>What lessons can be drawn from the community engagement and communication process to inform future community-led work?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>What would have been the impact if this initiative was not delivered or had prematurely ended?</td>
<td></td>
</tr>
</tbody>
</table>

### EQ11

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>EQ11</td>
<td>How effective was the initiative in meeting community needs?</td>
<td>How were community needs identified?</td>
<td>Primary: Surveys of: community members and groups, Assembly members and working groups, the Advocate Workshops with: community members and groups Existing meetings and events of: community members and groups, the Assembly and working groups Interviews with: the Advocate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Were these needs met?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>To what extent were community needs met?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>What factors influenced this?</td>
<td></td>
</tr>
</tbody>
</table>

### EQ12

<table>
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<th>ID</th>
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</tr>
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<tbody>
<tr>
<td>EQ12</td>
<td>How effective was the initiative in improving health and wellbeing in Latrobe?</td>
<td>How well was the initiative adaptively managed to provide accountability for high level objectives while remaining flexible and responsive to community-led activity?</td>
<td>Primary: Surveys of: community members and groups, Assembly members and working groups, the Advocate Workshops with: community members and groups Existing meetings and events of: community members and groups, the Assembly and working groups Interviews with: the Advocate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Did the initiative meet its objectives within the allocated budget and timeframe?</td>
<td></td>
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Evaluation questions
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<tr>
<td>EQ13</td>
<td>Is there evidence of the initiative's ongoing sustainability?</td>
<td>Do community members feel there is a need for the initiative to continue? Are community members entrenched in the management and delivery of the initiative? Given the observed or measurable effect of the initiative, what are the ethical considerations of deciding whether or not to continue the initiative?</td>
<td>Primary: Surveys of: community members and groups, Assembly members and working groups, the Advocate Workshops with: community members and groups Existing meetings and events of: community members and groups, the Assembly and working groups Interviews with: the Advocate</td>
</tr>
<tr>
<td>EQ14</td>
<td>How could the initiative be re-scoped or otherwise enhanced?</td>
<td>What aspects of the initiative appear to have supported success?</td>
<td>Primary: Surveys of: community members and groups, Assembly members and working groups, the Advocate Workshops with: community members and groups Existing meetings and events of: community members and groups, the Assembly and working groups Interviews with: the Advocate</td>
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Mapping short term outcomes to evaluation questions

Given the broad nature of health and wellbeing, and the formative stage of these initiatives, the evaluation will reference a broad range of outcomes and evaluation questions

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Initiative</th>
<th>Timeframe</th>
<th>Impact</th>
<th>Development EQs</th>
<th>Outcome EQs</th>
</tr>
</thead>
<tbody>
<tr>
<td>(SO1) Sectors within Latrobe are aware the region is a designated Zone, including sectors not traditionally associated with health such as small business and education</td>
<td>Zone</td>
<td>Short</td>
<td>IA1</td>
<td>X X X X X X</td>
<td></td>
</tr>
<tr>
<td>(SO2) Sectors work together in new ways to improve opportunities available in the Zone</td>
<td>Zone</td>
<td>Short</td>
<td>IA1</td>
<td>X X X X X X</td>
<td></td>
</tr>
<tr>
<td>(SO3) The community are aware of and understand the purpose of the Zone</td>
<td>Zone</td>
<td>Short</td>
<td>IA2</td>
<td>X X X X X X</td>
<td></td>
</tr>
<tr>
<td>(SO4) The community feel ownership of the charter for the Zone</td>
<td>Zone</td>
<td>Short</td>
<td>IA2</td>
<td>X X X X X X</td>
<td></td>
</tr>
<tr>
<td>(SO5) The community participate in programs for the Zone</td>
<td>Zone</td>
<td>Short</td>
<td>IA2</td>
<td>X X X X X X</td>
<td></td>
</tr>
<tr>
<td>(SO6) The Zone is a focal point for the coordination and integration of health and wellbeing services, including service providers not traditionally associated with health such as employment, education and justice</td>
<td>Zone</td>
<td>Short</td>
<td>IA3</td>
<td>X X X X X X</td>
<td></td>
</tr>
<tr>
<td>(SO7) Local service providers invest in new ways of working together to improve service integration in the Zone</td>
<td>Zone</td>
<td>Short</td>
<td>IA3</td>
<td>X X X X X X</td>
<td></td>
</tr>
<tr>
<td>(SO10) The community has improved access to healthy social environments and activities</td>
<td>Zone</td>
<td>Short</td>
<td>IA4</td>
<td>X X X X X X</td>
<td></td>
</tr>
<tr>
<td>(SO8) The community are aware they are in the Zone when making choices related to their health and wellbeing</td>
<td>Zone</td>
<td>Short</td>
<td>IA4</td>
<td>X X X X X X</td>
<td></td>
</tr>
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Mapping short term outcomes to evaluation questions

Given the broad nature of health and wellbeing, and the formative stage of these initiatives, the evaluation will reference a broad range of outcomes and evaluation questions

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<tbody>
<tr>
<td>(SO9) The community has improved access to healthy options including healthy food and physical activity options</td>
<td>Zone</td>
<td>Short</td>
<td>IA4</td>
<td>X X X X X X X</td>
<td></td>
</tr>
<tr>
<td>(SO11) Sectors within Latrobe are influenced to improve local opportunities due to strong relationships between Assembly members and sector leaders including sectors not traditionally associated with health such as small business and education</td>
<td>Assembly</td>
<td>Short</td>
<td>IA1</td>
<td>X X X X X X X</td>
<td></td>
</tr>
<tr>
<td>(SO12) Sectors plan, develop and implement programs to improve local opportunities</td>
<td>Assembly</td>
<td>Short</td>
<td>IA1</td>
<td>X X X X X X X</td>
<td></td>
</tr>
<tr>
<td>(SO13) The community are aware of the Assembly and understands their role</td>
<td>Assembly</td>
<td>Short</td>
<td>IA2</td>
<td>X X X X X X X</td>
<td></td>
</tr>
<tr>
<td>(SO14) The community are supported to plan, develop and implement programs</td>
<td>Assembly</td>
<td>Short</td>
<td>IA2</td>
<td>X X X X X X X</td>
<td></td>
</tr>
<tr>
<td>(SO15) Health and wellbeing service providers within Latrobe are influenced to improve the type and volume of services due to strong relationships between Assembly members and service provider leaders, including those not traditionally associated with health such as employment, education and justice</td>
<td>Assembly</td>
<td>Short</td>
<td>IA3</td>
<td>X X X X X X X</td>
<td></td>
</tr>
<tr>
<td>(SO16) Service providers plan, develop and implement services to address local health and wellbeing service gaps</td>
<td>Assembly</td>
<td>Short</td>
<td>IA3</td>
<td>X X X X X X X</td>
<td></td>
</tr>
<tr>
<td>(SO17) The community has improved access to health and wellbeing educational materials</td>
<td>Assembly</td>
<td>Short</td>
<td>IA4</td>
<td>X X X X X X X</td>
<td></td>
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Mapping short term outcomes to evaluation questions
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<tbody>
<tr>
<td>(SO18) The community has improved access to healthy options including healthy food and physical activity options</td>
<td>Assembly</td>
<td>Short</td>
<td>IA4</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>(SO19) The community has improved access to healthy social environments and activities</td>
<td>Assembly</td>
<td>Short</td>
<td>IA4</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>(SO20) Latrobe and the community’s needs are better represented to the Government due to strong relationships between the Advocate and key government stakeholders</td>
<td>Advocate</td>
<td>Short</td>
<td>IA1</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>(SO21) The community are aware of and understand the role of the Advocate</td>
<td>Advocate</td>
<td>Short</td>
<td>IA2</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>(SO22) The community feel heard, respected and understood by the Advocate</td>
<td>Advocate</td>
<td>Short</td>
<td>IA2</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>(SO23) The community have confidence in the Advocate’s ability to represent their needs</td>
<td>Advocate</td>
<td>Short</td>
<td>IA2</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>(SO24) The Advocate is a respected representative of the community in health and wellbeing service planning at a local and State level</td>
<td>Advocate</td>
<td>Short</td>
<td>IA3</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>(SO25) The community’s health and wellbeing needs are communicated</td>
<td>Advocate</td>
<td>Short</td>
<td>IA3</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>(SO26) The Advocate is a focal point for health and wellbeing leadership within the community</td>
<td>Advocate</td>
<td>Short</td>
<td>IA4</td>
<td>X</td>
<td>X</td>
</tr>
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Mapping medium term outcomes to evaluation questions

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</tr>
</thead>
<tbody>
<tr>
<td>(MO1) New ways of working improve opportunities available in the Zone</td>
<td>Zone</td>
<td>Medium</td>
<td>IA1</td>
<td>X X X</td>
<td>X X X X X X X</td>
</tr>
<tr>
<td>(MO2) New ways of working are embedded in sector organisations</td>
<td>Zone</td>
<td>Medium</td>
<td>IA1</td>
<td>X X X</td>
<td>X X X X X X X</td>
</tr>
<tr>
<td>(MO3) Increased community participation leads to improved social connections</td>
<td>Zone</td>
<td>Medium</td>
<td>IA2</td>
<td>X X X</td>
<td>X X X X X X X</td>
</tr>
<tr>
<td>(MO4) The community lead programs for the Zone</td>
<td>Zone</td>
<td>Medium</td>
<td>IA2</td>
<td>X X X</td>
<td>X X X X X X X</td>
</tr>
<tr>
<td>(MO5) &quot;No wrong door&quot; – The community are put in touch with the service they need regardless of who they contact first</td>
<td>Zone</td>
<td>Medium</td>
<td>IA3</td>
<td>X X X</td>
<td>X X X X X X X</td>
</tr>
<tr>
<td>(MO6) New ways of working are embedded in service providers</td>
<td>Zone</td>
<td>Medium</td>
<td>IA3</td>
<td>X X X</td>
<td>X X X X X X X</td>
</tr>
<tr>
<td>(MO7) The community make positive changes to their health and wellbeing behaviours</td>
<td>Zone</td>
<td>Medium</td>
<td>IA4</td>
<td>X X X</td>
<td>X X X X X X X</td>
</tr>
<tr>
<td>(MO8) The community encourage their friends and family to make positive changes to their health and wellbeing behaviours</td>
<td>Zone</td>
<td>Medium</td>
<td>IA4</td>
<td>X X X</td>
<td>X X X X X X X</td>
</tr>
<tr>
<td>(MO9) The community has improved access to opportunities</td>
<td>Assembly</td>
<td>Medium</td>
<td>IA1</td>
<td>X X X</td>
<td>X X X X X X X</td>
</tr>
<tr>
<td>(MO10) Programs are community-led with support from the Assembly where required</td>
<td>Assembly</td>
<td>Medium</td>
<td>IA2</td>
<td>X X X</td>
<td>X X X X X X X</td>
</tr>
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Mapping medium term outcomes to evaluation questions

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<tbody>
<tr>
<td>(MO11) The community feel trusted and empowered to lead community programs</td>
<td>Assembly</td>
<td>Medium</td>
<td>IA2</td>
<td>+ + +</td>
<td>+ + + + + + + +</td>
</tr>
<tr>
<td>(MO12) The community has improved access to local, culturally appropriate, specialist services for chronic disease, mental health, alcohol and other drugs, and preventive health</td>
<td>Assembly</td>
<td>Medium</td>
<td>IA3</td>
<td>+ + +</td>
<td>+ + + + + + + +</td>
</tr>
<tr>
<td>(MO13) The community has increased health and wellbeing service utilisation</td>
<td>Assembly</td>
<td>Medium</td>
<td>IA3</td>
<td>+ + +</td>
<td>+ + + + + + + +</td>
</tr>
<tr>
<td>(MO14) Unwell people are supported to live well</td>
<td>Assembly</td>
<td>Medium</td>
<td>IA3</td>
<td>+ + +</td>
<td>+ + + + + + + +</td>
</tr>
<tr>
<td>(MO15) The community has improved physical activity levels</td>
<td>Assembly</td>
<td>Medium</td>
<td>IA4</td>
<td>+ + +</td>
<td>+ + + + + + + +</td>
</tr>
<tr>
<td>(MO16) The community has improved nutritional practices</td>
<td>Assembly</td>
<td>Medium</td>
<td>IA4</td>
<td>+ + +</td>
<td>+ + + + + + + +</td>
</tr>
<tr>
<td>(MO17) The community has reduced risky alcohol behaviours</td>
<td>Assembly</td>
<td>Medium</td>
<td>IA4</td>
<td>+ + +</td>
<td>+ + + + + + + +</td>
</tr>
<tr>
<td>(MO18) The community has reduced gambling behaviours</td>
<td>Assembly</td>
<td>Medium</td>
<td>IA4</td>
<td>+ + +</td>
<td>+ + + + + + + +</td>
</tr>
<tr>
<td>(MO19) Policy decisions reflect that the Government understands the positives of Latrobe</td>
<td>Advocate</td>
<td>Medium</td>
<td>IA1</td>
<td>+ + +</td>
<td>+ + + + + + + +</td>
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<tbody>
<tr>
<td>(MO20) Policy decisions reflect that the Government understands the community’s needs</td>
<td>Advocate</td>
<td>Medium</td>
<td>IA1</td>
<td>4 5 6 7 8 9</td>
<td>10 11 12 13 14 15</td>
</tr>
<tr>
<td>(MO21) The community’s concerns are addressed more effectively</td>
<td>Advocate</td>
<td>Medium</td>
<td>IA2</td>
<td></td>
<td>10 11 12 13 14 15</td>
</tr>
<tr>
<td>(MO22) The community feel empowered and enabled to advocate for their health and wellbeing</td>
<td>Advocate</td>
<td>Medium</td>
<td>IA2</td>
<td></td>
<td>10 11 12 13 14 15</td>
</tr>
<tr>
<td>(MO23) The community has improved access to affordable services</td>
<td>Advocate</td>
<td>Medium</td>
<td>IA3</td>
<td></td>
<td>10 11 12 13 14 15</td>
</tr>
<tr>
<td>(MO24) The community has improved access to local, culturally appropriate, specialist services for chronic disease, mental health, alcohol and other drugs, and preventive health</td>
<td>Advocate</td>
<td>Medium</td>
<td>IA3</td>
<td></td>
<td>10 11 12 13 14 15</td>
</tr>
<tr>
<td>(MO25) &quot;No wrong door” – The community are put in touch with the service they need regardless of who they contact first</td>
<td>Advocate</td>
<td>Medium</td>
<td>IA3</td>
<td></td>
<td>10 11 12 13 14 15</td>
</tr>
<tr>
<td>(MO26) The community feel empowered to make positive changes to their health and wellbeing behaviours</td>
<td>Advocate</td>
<td>Medium</td>
<td>IA4</td>
<td></td>
<td>10 11 12 13 14 15</td>
</tr>
</tbody>
</table>
## Mapping long term outcomes to evaluation questions

The long term outcomes identified (post 2020) are beyond the timeframe of this evaluation, however, these should be considered in any ongoing monitoring and evaluation or future outcome evaluation.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Initiative</th>
<th>Timeframe</th>
<th>Impact</th>
<th>Development EQs</th>
<th>Outcome EQs</th>
</tr>
</thead>
<tbody>
<tr>
<td>(LO1) New ways of working lead people external to the community to view Latrobe as a healthy city</td>
<td>Zone</td>
<td>Long</td>
<td>IA1</td>
<td>4 5 6 7 8 9</td>
<td>10 11 12 13 14 15</td>
</tr>
<tr>
<td>(LO2) The community has improved capacity to develop and implement community programs</td>
<td>Zone</td>
<td>Long</td>
<td>IA2</td>
<td></td>
<td>X X X X X X</td>
</tr>
<tr>
<td>(LO3) The community has improved resilience</td>
<td>Zone</td>
<td>Long</td>
<td>IA2</td>
<td></td>
<td>X X X X X X</td>
</tr>
<tr>
<td>(LO4) New ways of working attract health and wellbeing professionals to the Zone</td>
<td>Zone</td>
<td>Long</td>
<td>IA3</td>
<td></td>
<td>X X X X X X</td>
</tr>
<tr>
<td>(LO5) The community has a culture of healthy living</td>
<td>Zone</td>
<td>Long</td>
<td>IA4</td>
<td></td>
<td>X X X X X X</td>
</tr>
<tr>
<td>(LO6) The community has improved health outcomes including reduced chronic disease and mental health</td>
<td>Zone</td>
<td>Long</td>
<td>IA4</td>
<td></td>
<td>X X X X X X</td>
</tr>
<tr>
<td>(LO7) Improved opportunities lead people external to the community to view Latrobe as a healthy city</td>
<td>Assembly</td>
<td>Long</td>
<td>IA2</td>
<td></td>
<td>X X X X X X</td>
</tr>
<tr>
<td>(LO8) The community has improved capacity to act in a protective manner to prevent issues from becoming acute</td>
<td>Assembly</td>
<td>Long</td>
<td>IA2</td>
<td></td>
<td>X X X X X X</td>
</tr>
<tr>
<td>(LO9) The community are confident that they, their family and their friends can access the health and wellbeing services they need, when they need them</td>
<td>Assembly</td>
<td>Long</td>
<td>IA3</td>
<td></td>
<td>X X X X X X</td>
</tr>
</tbody>
</table>

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Mapping long term outcomes to evaluation questions
The long term outcomes identified (post 2020) are beyond the timeframe of this evaluation, however, these should be considered in any ongoing monitoring and evaluation or future outcome evaluation

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Initiative</th>
<th>Timeframe</th>
<th>Impact</th>
<th>Development EQs</th>
<th>Outcome EQs</th>
</tr>
</thead>
<tbody>
<tr>
<td>(LO10) The community has improved health outcomes including reduced chronic disease and mental health</td>
<td>Assembly</td>
<td>Long</td>
<td>IA4</td>
<td>X X X X X X X</td>
<td></td>
</tr>
<tr>
<td>(LO11) The community has improved confidence in the Government’s ability to understand the positives of Latrobe and meet their needs</td>
<td>Advocate</td>
<td>Long</td>
<td>IA1</td>
<td>X X X X X X X</td>
<td></td>
</tr>
<tr>
<td>(LO12) The community has greater capacity to advocate for their health and wellbeing needs</td>
<td>Advocate</td>
<td>Long</td>
<td>IA2</td>
<td>X X X X X X X</td>
<td></td>
</tr>
<tr>
<td>(LO13) The community are confident that they, their family and their friends can access the health and wellbeing services they need, when they need them and at an affordable cost</td>
<td>Advocate</td>
<td>Long</td>
<td>IA3</td>
<td>X X X X X X X</td>
<td></td>
</tr>
<tr>
<td>(LO14) The community has a culture of healthy living</td>
<td>Advocate</td>
<td>Long</td>
<td>IA4</td>
<td>X X X X X X X</td>
<td></td>
</tr>
</tbody>
</table>
## Mapping impact areas to data sources and indicators

Given the broad nature of health and wellbeing, and the formative stage of these initiatives, the evaluation will reference a broad range of indicators and data sources. These may include:

<table>
<thead>
<tr>
<th>Impact</th>
<th>Data source</th>
<th>Related indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>(IA2) Improved community connectedness and participation</td>
<td>VPHS</td>
<td>Feelings of safety</td>
</tr>
<tr>
<td>VPHS</td>
<td>Feelings of trust</td>
<td></td>
</tr>
<tr>
<td>VPHS</td>
<td>Help from a volunteer organisation</td>
<td></td>
</tr>
<tr>
<td>VPHS</td>
<td>Help from family when required</td>
<td></td>
</tr>
<tr>
<td>VPHS</td>
<td>Help from friends when required</td>
<td></td>
</tr>
<tr>
<td>VPHS</td>
<td>Help from neighbours when required</td>
<td></td>
</tr>
<tr>
<td>VPHS</td>
<td>Help with care in an emergency</td>
<td></td>
</tr>
<tr>
<td>VPHS</td>
<td>Opportunity to have a say</td>
<td></td>
</tr>
<tr>
<td>VPHS</td>
<td>Valued by society</td>
<td></td>
</tr>
<tr>
<td>VPHS</td>
<td>Volunteering</td>
<td></td>
</tr>
<tr>
<td>VicHealth Indicators Survey</td>
<td>Perceptions of safety – walking alone during day</td>
<td></td>
</tr>
<tr>
<td>VicHealth Indicators Survey</td>
<td>Perceptions of safety – walking alone after dark</td>
<td></td>
</tr>
<tr>
<td>VicHealth Indicators Survey</td>
<td>Resilience</td>
<td></td>
</tr>
<tr>
<td>VicHealth Indicators Survey</td>
<td>Perceptions of neighbourhood – people are willing to help each other</td>
<td></td>
</tr>
<tr>
<td>VicHealth Indicators Survey</td>
<td>Perceptions of neighbourhood – this is a close-knit neighbourhood</td>
<td></td>
</tr>
<tr>
<td>VicHealth Indicators Survey</td>
<td>Perceptions of neighbourhood – people can be trusted</td>
<td></td>
</tr>
<tr>
<td>VicHealth Indicators Survey</td>
<td>Participation in citizen engagement (in the last year)</td>
<td></td>
</tr>
</tbody>
</table>
Mapping impacts to indicators and data sources

Given the broad nature of health and wellbeing, and the formative stage of these initiatives, the evaluation will reference a broad range of indicators and data sources. These may include:

<table>
<thead>
<tr>
<th>Impact</th>
<th>Data source</th>
<th>Related indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>(IA2) Improved community connectedness and participation</td>
<td>VicHealth Indicators Survey</td>
<td>Attended arts activities or events (in the last 3 months)</td>
</tr>
<tr>
<td></td>
<td>VicHealth Indicators Survey</td>
<td>Made or created art or crafts (in the last 3 months)</td>
</tr>
<tr>
<td></td>
<td>VicHealth Indicators Survey</td>
<td>Social networking used to organise time with friends/family</td>
</tr>
<tr>
<td></td>
<td>VicHealth Indicators Survey</td>
<td>Community acceptance of diverse cultures</td>
</tr>
<tr>
<td></td>
<td>VicHealth Indicators Survey</td>
<td>Prepared to intervene in a situation of domestic violence</td>
</tr>
<tr>
<td></td>
<td>LGA Statistical Profile</td>
<td>People who help as volunteer</td>
</tr>
<tr>
<td>(IA3) Improved health service access and design</td>
<td>VPHS</td>
<td>Blood cholesterol check (% in previous 2 years)</td>
</tr>
<tr>
<td></td>
<td>VPHS</td>
<td>Blood pressure check (% in previous 2 years)</td>
</tr>
<tr>
<td></td>
<td>VPHS</td>
<td>Bowel cancer check in those aged 50 years and above (% in previous 2 years)</td>
</tr>
<tr>
<td></td>
<td>VPHS</td>
<td>Mammogram in those aged 50-69 years (% tested in previous 2 years)</td>
</tr>
<tr>
<td></td>
<td>VPHS</td>
<td>Pap smear (% tested in previous 2 years)</td>
</tr>
<tr>
<td></td>
<td>LGA Statistical Profile</td>
<td>People who delayed medical consultation, unable to afford</td>
</tr>
<tr>
<td></td>
<td>LGA Statistical Profile</td>
<td>People who delayed purchasing prescribed medication, unable to afford</td>
</tr>
<tr>
<td></td>
<td>LGA Statistical Profile</td>
<td>Breast cancer screening participation</td>
</tr>
<tr>
<td></td>
<td>LGA Statistical Profile</td>
<td>Cervical cancer screening participation</td>
</tr>
<tr>
<td></td>
<td>LGA Statistical Profile</td>
<td>Bowel cancer screening participation</td>
</tr>
<tr>
<td></td>
<td>LGA Statistical Profile</td>
<td>Children fully immunised between 24 and 27 months</td>
</tr>
</tbody>
</table>
Mapping impacts to indicators and data sources

Given the broad nature of health and wellbeing, and the formative stage of these initiatives, the evaluation will reference a broad range of indicators and data sources. These may include:

<table>
<thead>
<tr>
<th>Impact</th>
<th>Data source</th>
<th>Related indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>LGA Statistical Profile</td>
<td>Children attending 3.5 year old maternal and child health checks</td>
</tr>
<tr>
<td></td>
<td>LGA Statistical Profile</td>
<td>Aged care residential places</td>
</tr>
<tr>
<td></td>
<td>LGA Statistical Profile</td>
<td>General practitioners per 1,000 population</td>
</tr>
<tr>
<td></td>
<td>LGA Statistical Profile</td>
<td>General practice clinics per 1,000 population</td>
</tr>
<tr>
<td></td>
<td>LGA Statistical Profile</td>
<td>Allied health service sites per 1,000 population</td>
</tr>
<tr>
<td></td>
<td>LGA Statistical Profile</td>
<td>Dental service sites per 1,000 population</td>
</tr>
<tr>
<td></td>
<td>LGA Statistical Profile</td>
<td>Pharmacies per 1,000 population</td>
</tr>
<tr>
<td></td>
<td>LGA Statistical Profile</td>
<td>GP attendances per 1,000 population</td>
</tr>
<tr>
<td></td>
<td>LGA Statistical Profile</td>
<td>GP attendances per 1,000 females</td>
</tr>
<tr>
<td></td>
<td>LGA Statistical Profile</td>
<td>GP attendances per 1,000 males</td>
</tr>
<tr>
<td></td>
<td>LGA Statistical Profile</td>
<td>Specialist attendances per 1,000 population</td>
</tr>
<tr>
<td></td>
<td>LGA Statistical Profile</td>
<td>Diagnostic imaging services per 1,000 population</td>
</tr>
<tr>
<td></td>
<td>LGA Statistical Profile</td>
<td>People who attended a GP</td>
</tr>
<tr>
<td></td>
<td>LGA Statistical Profile</td>
<td>Females who attended a GP</td>
</tr>
<tr>
<td></td>
<td>LGA Statistical Profile</td>
<td>Males who attended a GP</td>
</tr>
<tr>
<td></td>
<td>LGA Statistical Profile</td>
<td>People who attended a specialist</td>
</tr>
<tr>
<td></td>
<td>LGA Statistical Profile</td>
<td>Females who attended a specialist</td>
</tr>
</tbody>
</table>
Mapping impacts to indicators and data sources

Given the broad nature of health and wellbeing, and the formative stage of these initiatives, the evaluation will reference a broad range of indicators and data sources. These may include:

<table>
<thead>
<tr>
<th>Impact</th>
<th>Data source</th>
<th>Related indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>(IA4) Improved health and lifestyle</td>
<td>VPHS</td>
<td>Prevalence of asthma (% experiencing symptoms in previous 12 months)</td>
</tr>
<tr>
<td></td>
<td>VPHS</td>
<td>Prevalence of overweight/obesity (% based on BMI)</td>
</tr>
<tr>
<td></td>
<td>VPHS</td>
<td>Prevalence by type of diabetes (%)</td>
</tr>
<tr>
<td></td>
<td>VPHS</td>
<td>Alcohol-related harm (% at long-term risk)</td>
</tr>
<tr>
<td></td>
<td>VPHS</td>
<td>Alcohol-related harm (% at short-term risk)</td>
</tr>
<tr>
<td></td>
<td>VPHS</td>
<td>Fruit &amp; vegetable consumption (% meeting guidelines)</td>
</tr>
<tr>
<td></td>
<td>VPHS</td>
<td>Physical activity (% meeting guidelines)</td>
</tr>
<tr>
<td></td>
<td>VPHS</td>
<td>Risk of alcohol related injury on a single occasion of drinking (%)</td>
</tr>
<tr>
<td></td>
<td>VPHS</td>
<td>Smoking status (%)</td>
</tr>
<tr>
<td></td>
<td>VPHS</td>
<td>Prevalence of depression/anxiety (%)</td>
</tr>
<tr>
<td></td>
<td>VPHS</td>
<td>Prevalence of psychological distress (% based on Kessler 10 score)</td>
</tr>
<tr>
<td></td>
<td>VPHS</td>
<td>Prevalence of cancer (5)</td>
</tr>
<tr>
<td></td>
<td>VPHS</td>
<td>Prevalence of heart disease (%)</td>
</tr>
<tr>
<td></td>
<td>VPHS</td>
<td>Prevalence of stroke (%)</td>
</tr>
<tr>
<td></td>
<td>VPHS</td>
<td>Self-reported health status (%)</td>
</tr>
<tr>
<td></td>
<td>VPHS</td>
<td>Financial stress (%)</td>
</tr>
<tr>
<td></td>
<td>VPHS</td>
<td>Food insecurity (%)</td>
</tr>
</tbody>
</table>
Mapping impacts to indicators and data sources

Given the broad nature of health and wellbeing, and the formative stage of these initiatives, the evaluation will reference a broad range of indicators and data sources. These may include:

<table>
<thead>
<tr>
<th>Impact</th>
<th>Data source</th>
<th>Related indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>(IA4) Improved health and lifestyle</td>
<td>VicHealth Indicators Survey</td>
<td>Subjective wellbeing</td>
</tr>
<tr>
<td></td>
<td>VicHealth Indicators Survey</td>
<td>Satisfaction with life as a whole</td>
</tr>
<tr>
<td></td>
<td>VicHealth Indicators Survey</td>
<td>Physical activity (0 days per week)</td>
</tr>
<tr>
<td></td>
<td>VicHealth Indicators Survey</td>
<td>Physical activity (4 or more days per week)</td>
</tr>
<tr>
<td></td>
<td>VicHealth Indicators Survey</td>
<td>Participation in any organised physical activity</td>
</tr>
<tr>
<td></td>
<td>VicHealth Indicators Survey</td>
<td>Organised by a fitness, leisure or indoor sports centre</td>
</tr>
<tr>
<td></td>
<td>VicHealth Indicators Survey</td>
<td>Organised by a sports club or association</td>
</tr>
<tr>
<td></td>
<td>VicHealth Indicators Survey</td>
<td>Participation in any non-organised physical activity</td>
</tr>
<tr>
<td></td>
<td>VicHealth Indicators Survey</td>
<td>Activity type – walking</td>
</tr>
<tr>
<td></td>
<td>VicHealth Indicators Survey</td>
<td>Activity type – jogging or running</td>
</tr>
<tr>
<td></td>
<td>VicHealth Indicators Survey</td>
<td>Activity type – cycling</td>
</tr>
</tbody>
</table>
5. Governance and project management
Governance and project management
An overview of the evaluation governance and project management

The Deloitte evaluation team will have regular contact with DHHS via the following groups:

- **Latrobe Health and Wellbeing Steering Committee**: Comprising DHHS Senior Executives, DHHS Central members and DHHS Traralgon members (Deloitte will attend meetings on a quarterly basis (approximately)).

- **Evaluation reference group**: Comprising DHHS Central members, DHHS Traralgon members, the Latrobe Health Assembly Executive Officer (monthly meetings).

- **DHHS project team**: Comprising DHHS Traralgon (weekly meetings).

The governance and project management structure for the evaluation is as follows:
6. Risk assessment and ethics
Ethics

The evaluation will abide by the Australasian Evaluation Society (AES) principles and guidelines for the ethical conduct of evaluations

Australasian Evaluation Society (AES) principles and guidelines for the ethical conduct of evaluations considered particularly relevant for this evaluation have been listed below.

While the evaluation will abide by all AES principles and guidelines for the ethical conduct of evaluations, the historical and cultural context in Latrobe community requires that particular emphasis be given to the following principles and guidelines.

**Ethical principles**

• An evaluation should be designed, conducted and reported in a manner that respects the rights, privacy, dignity and entitlements of those affected by and contributing to the evaluation.

• Reciprocity. Participants giving their information to researchers should reap some benefit. For example, the findings of the evaluation should be made available and where possible presented to participants, providing information of benefit to them and their wider community.

• The evaluation should be reported in such a way that audiences are provided with a fair and balanced response to the terms of reference for the evaluation. Many if not most evaluations will have multiple audiences, and the needs of each should be taken into account.

**Ethical guidelines**

• **Consider implications of differences and inequalities:** Account should be taken in the design, the conduct and the reporting of evaluations of the potential effects of differences and inequalities in society related to race, age, gender, sexual orientation, physical or intellectual ability, religion, socio-economic or ethnic background. Particular regard should be given to any rights, protocols, treaties, legislative or legal guidelines which apply.

• **Obtain informed consent:** The informed consent of those directly providing information should be obtained, preferably in writing. They should be advised as to what information will be sought, how the information will be recorded and used, and the likely risks and benefits arising from their participation in the evaluation. In the case of minors and other dependents, informed consent must be sought from parents or guardians.
Ethics

The evaluation will abide by the Australasian Evaluation Society (AES) principles and guidelines for the ethical conduct of evaluations

Ethical guidelines (continued)

• **Maintain confidentiality:** During the course of the evaluation, the results and other findings should be held as confidential until released by the commissioner, and in accordance with any consent arrangements agreed with contributors. Confidentiality arrangements should extend to the storage and disposal of all information collected. Consent arrangements may include provision for release of information for purposes of formative evaluation and for purposes of validation of evaluation findings.

• **Report significant problems:** If the evaluator discovers evidence of an unexpected and significant problem with the program under evaluation or related matters, they should report this as soon as possible to the commissioner of the evaluation, unless this constitutes a breach of rights for those concerned. Where the evaluator discovers evidence of significant problems with the conduct of the evaluation by other evaluators or by the commissioner of the evaluation, this should be referred to the Board of the AES.

• **Anticipate trauma:** Evaluations involving interviews or focus groups on sensitive topics such as crime, sexual violence and family dysfunction run the risk of awakening or re-awakening trauma in participants and sometimes in evaluators. Areas of potential trauma should be avoided where possible; where they must be addressed, mechanisms need to be put in place to ensure counselling and/or support for participants and evaluators is available if required. Protocols for terminating interviews if distress occurs should be built into the evaluation design.

• **Report clearly and simply:** The results of the evaluation should be presented as clearly and simply as accuracy allows so that clients and other stakeholders can easily understand the evaluation process and results. Communications that are tailored to a given stakeholder should include all important results, and also be shaped to respect the communication styles of the stakeholders. The reciprocity principle requires that evaluation findings be made available to evaluands; relevant language, literacy and cultural communication issues should be taken into account.

• **Report fairly, accurately and comprehensively:** Oral and written evaluation reports should be direct, comprehensive and honest in the disclosure of findings and the limitations of the evaluation. Reports should interpret and present evidence and conclusions in a fair manner, and include sufficient details of their methodology and findings to substantiate their conclusions. Minority perspectives and experiences should be identified and reported fairly.
7. Reporting and dissemination
The audience for this document; the evaluation framework, and the feedback produced throughout the evaluation is the Latrobe community, the Assembly, the Advocate and DHHS.

At present, the following reporting dates are agreed:

- Identification and reporting on early progress – February 2018;
- Progress tracking and opportunity identification – April 2018;
- Interim report (formal deliverable) – June 2018; and
- Final report (formal deliverable) – March 2020.

In addition to the above dates, the evaluation will provide informal feedback at periodic intervals to assist in improving these initiatives as they occur, and actively including the community and people who are part of the initiatives in this process. This feedback will primarily be shared via the Latrobe Health Innovation Zone Evaluation Facebook. A community forum or presentation may also be conducted.

Other potential ideas for sharing information are listed below. One or more of these ideas may be used following further discussion.

- Case studies following projects developed by the Assembly;
- Dashboards displaying whether the initiatives are ‘on track’, ‘generally on track with a few opportunities for improvement’ or ‘off track’ toward achieving defined outcomes;
- Videos presented by community members explaining deliverables or other evaluation feedback for community distribution;
- Articles on deliverables or other evaluation feedback in local media such as the Latrobe Valley Express;
- Radio interviews discussing deliverables or other evaluation feedback; and
- Visual representations of socio-metric analysis of survey responses including basic theming of qualitative responses, descriptive or inferential statistics, graphs or socio-metric diagrams and network maps.
Appendix A:
Demographic data and other community characteristics
Demographic data and other community characteristics
Latrobe LGA 2016 Census

<table>
<thead>
<tr>
<th>Latrobe City</th>
<th>Victoria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count</td>
<td>%</td>
</tr>
<tr>
<td>Male</td>
<td>35,788</td>
</tr>
<tr>
<td>Female</td>
<td>37,469</td>
</tr>
<tr>
<td>Aboriginal and/or Torres Strait Islander people</td>
<td>1,184</td>
</tr>
<tr>
<td>One parent family</td>
<td>3,744</td>
</tr>
<tr>
<td>Internet not accessed from dwelling</td>
<td>5,507</td>
</tr>
<tr>
<td>English only spoken at home</td>
<td>62,594</td>
</tr>
<tr>
<td>Households where a non-English language is spoken</td>
<td>2,694</td>
</tr>
</tbody>
</table>

**Employment**

<table>
<thead>
<tr>
<th>Latrobe City</th>
<th>Victoria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worked full-time</td>
<td>16,856</td>
</tr>
<tr>
<td>Worked part-time</td>
<td>10,736</td>
</tr>
<tr>
<td>Away from work</td>
<td>1,902</td>
</tr>
<tr>
<td>Unemployed</td>
<td>3,157</td>
</tr>
</tbody>
</table>

**Weekly incomes**

<table>
<thead>
<tr>
<th>Latrobe City</th>
<th>Victoria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count</td>
<td>%</td>
</tr>
<tr>
<td>Personal</td>
<td>544</td>
</tr>
<tr>
<td>Family</td>
<td>1,415</td>
</tr>
<tr>
<td>Household</td>
<td>1,078</td>
</tr>
</tbody>
</table>

**Rent weekly payments**

<table>
<thead>
<tr>
<th>Latrobe City</th>
<th>Victoria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median rent</td>
<td>200</td>
</tr>
<tr>
<td>Households where rent payments are less than 30% of household income</td>
<td>--</td>
</tr>
<tr>
<td>Households with rent payments greater than or equal to 30% of household income</td>
<td>--</td>
</tr>
</tbody>
</table>

**Mortgage monthly repayments**

<table>
<thead>
<tr>
<th>Latrobe City</th>
<th>Victoria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median mortgage repayments</td>
<td>1,200</td>
</tr>
<tr>
<td>Households where mortgage repayments are less than 30% of household income</td>
<td>--</td>
</tr>
<tr>
<td>Households with mortgage repayments greater than or equal to 30% of household income</td>
<td>--</td>
</tr>
</tbody>
</table>
Appendix B: Review of similar initiatives
The Ottawa Charter for Health Promotion (WHO, 1986) defines health promotion as “the process of enabling people to increase control over, and to improve their health” (WHO, 1986). Since its inception, the Ottawa Charter has been a seminal resource for a “new public health movement around the world” (WHO, 1986).

This public health movement has led three decades of health interventions around the world which aim to be underpinned by five priority action areas identified in the Ottawa.

These priority action areas are:

- Build healthy public policy
- Create supportive environments for health
- Strengthen community action for health
- Develop personal skills
- Re-orient health services.

A number of health promotion interventions began to develop around the same time as the signing of the Ottawa Charter.

For example, the Healthy Communities movement emerged in Canada in the 1980s in response to growing realisation that interventions designed to improve population level health outcomes needed to build on community’s existing capacity to improve health and wellbeing.

The following building blocks were identified as part of the Healthy Communities approach:

- Community/citizen engagement
- Multi-sectoral collaboration
- Political commitment
- Healthy public policy
- Asset-based community development (Ontario Healthy Communities Coalition, ND).

In the Ottawa Charter, the World Health Organisation (WHO) asserted that “the prerequisites and prospects for health cannot be ensured by the health sector alone” and called for “coordinated action by all concerned: by governments, by health and other social and economic sectors, by nongovernmental and voluntary organizations, by local authorities, by industry and by the media” (WHO, 1986).

By the late 1990s health planners were searching for ways to define what healthy cities look like so that clear outcomes could be identified (Gudes, 2011). The extent to which a clear set of outcomes has been identified is arguable (Gudes, 2011). While there is now a growing evidence base surrounding the implementation of health promotion interventions that are grounded in the principles outlined in the Ottawa Charter, it has been argued that the healthy cities movement has not yet achieved its full potential (Gudes, 2011).
Review of similar initiatives

Place-based approaches

There is now widespread agreement that there is a “close relationship between living and working conditions and health outcomes” (Australian Institute of Health and Welfare, 2016).

Place-based health promotion interventions attempt to build community capacity while addressing the social determinants of health in a particular region/regions (Department of Health and Human Services, 2012).

Place-based approaches can be defined as “stakeholders engaging in a collaborative process to address issues as they are experienced within a geographic space, such as a neighbourhood or community” (Department of Health and Human Services, 2012).

The Tasmanian Department of Health and Human Services (Department of Health and Human Services, 2012) outlined the following key target areas for place-based approaches:

- Social capital
- Economic development
- Children and families
- Transport
- Housing
- Community engagement.

Frameworks for building healthy cities and communities

There are a number of major health promotion interventions around the world that have been developed to implement the principles outlined in the Ottawa Charter through activities aimed at building healthy cities. The most significant and relevant of these include:

- The WHO Healthy Cities project
- The Ontario Healthy Communities Coalition
- Health Action Zones in the UK
- Evaluation of Healthy Cities Noarlunga
- Healthy Together Victoria
- Go Goldfields.

The WHO Healthy Cities project

The WHO pioneered the establishment of healthy cities programs around the world. The WHO Healthy Cities project is now considered a ‘global movement’ with nearly 100 cities having membership in the WHO European Healthy Cities Network. The primary goal of the Healthy Cities project is to put health high on the social, economic and political agenda of city governments. According to the World Health Organisation’s regional Healthy Cities Guidelines, implementing the Healthy Cities framework means committing to a process of trying to achieve better physical and social environments and to “the development and maintenance of physical and social environments which support and promote better health and quality of life for residents” (WHO Regional Office for the Western Pacific, 2000).
Review of similar initiatives
Frameworks for building healthy cities and communities

The WHO Healthy Cities Practitioners’ Guide (World Health Organisation, 1995) provides the following objectives of the Healthy Cities project:

• To improve the health of urban dwellers and especially low income urban dwellers, through improved living conditions and better health services.

And sub-objectives:

• Increased awareness of health issues in urban development efforts
• Political mobilisation and community participation to prepare and implement a municipal health plan
• Increased capacity.

There is no single Healthy Cities model which is applicable to all regions. However many of the Healthy Cities projects around the world have shared their experiences and learnings. For example the Western Pacific Regional Guidelines (WHO Regional Office for the Western Pacific, 2000) offers a set of lessons which we have adapted into a set of building blocks that are essential to building a healthy city:

• Build on existing city initiatives in the region of interest
• Gain strong political support for coordination and resource mobilisation
• Develop a coordinating structure and an effective secretariat
• Activate active community participation and involvement
• Foster effective leadership
• Gain support from national coordinating units, the WHO and other partner agencies
• Record short-term achievements in addition to long-term goals
• Ensure sustainability of the Healthy Cities initiative
• Commit to evaluation, monitoring and indicators.

Outcomes identified by the World Health Organisation Healthy Cities project framework

In defining impacts and outcomes for Healthy Cities, de Leeuw (2011) states that those adopting the Healthy Cities framework must “embrace a value system for health that is a coherent, innovative urban health policy approach” (de Leeuw, 2011).

In evaluating the implementation of this approach, de Leeuw (2011) went on to state that it is crucial “to assess how the adoption of this value system would generate new and enhanced options for the actual implementation of [such] interventions” (de Leeuw, 2011).
Review of similar initiatives
Frameworks for building healthy cities and communities

De Leeuw (2011) proposes the following definitions:

- **Impact** – “a result or change that has come about as the result of complex interactions between a range of factors, including Healthy City designation, but potentially much wider (multi-causality, such as socio-political change, economic up/downturns, extending or limiting the range of stakeholders, etc.) and is driven by priorities determined by the Healthy Cities value system”

- **Outcomes** – “a result or change that can be directly attributed to such an activity or intervention within a Healthy City (if intervention A, then result Ax)” (de Leeuw, 2011).

De Leeuw cites the following as example outcomes:

- “With our Department of Parks and Leisure we started a program in community gardening and we have found that kids with a garden also make healthier food choices”

- “We established a committee to develop and monitor an HIA on the new ring road, and found that people have very specific ideas how this would affect their health” (adapted from de Leeuw, 2011).

The World Health Organisation proposes the following high level Outcome areas in their Model for the outcomes of a healthy city (World Health Organisation, 2014):

<table>
<thead>
<tr>
<th>Health protection</th>
<th>Citywide strategic policy</th>
<th>Strategic responses to climate change and for public health emergencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health promotion by scale</td>
<td>Citywide</td>
<td>Healthy urban planning</td>
</tr>
<tr>
<td>Neighbourhood</td>
<td>Healthy transport</td>
<td></td>
</tr>
<tr>
<td>Local environment</td>
<td>Healthy urban design</td>
<td></td>
</tr>
<tr>
<td>Lifestyle outcomes</td>
<td>Housing and regeneration</td>
<td></td>
</tr>
<tr>
<td>Health impacts</td>
<td>Creativity and liveability</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Safety and security</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Population’s ability for healthy living</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Health and health equity</td>
<td></td>
</tr>
</tbody>
</table>

There is a lack of established evaluation frameworks applicable to Healthy Cities projects (WHO Regional Office for the Western Pacific, 2000).

The Western Pacific Regional Guidelines propose the identification of:

- **Medium term indicators (in the areas of):**
  - Health literacy
  - Social action and influence
  - Healthy public policy and organisational practices
  - Healthy lifestyles
  - Healthy environments
  - Effective health services
Review of similar initiatives
Frameworks for building healthy cities and communities

- Health and development outcomes
- Specific individual, communal and environmental health outcomes such as:
  - Decline in morbidity and mortality from particular diseases
  - Improvement in river water quality
  - Increased health status (adapted from WHO Regional Office for the Western Pacific, 2000).

**Health Action Zones**

In 1997 the UK Government introduced a large long term (7 years) initiative to tackle health inequity. Health Action Zones, built upon multiagency partnership agreements, were established in 26 areas where high levels of social disadvantage were recorded.

The three broad strategic objectives of Health Action Zones (Department of Health and Human Services, 2012) were:

1. To identify and address the public health needs of the local area
2. To increase the effectiveness, efficiency and responsiveness of services; and
3. To develop partnerships for improving people’s health and relevant services.

According to a report by the Tasmanian Department of Health and Human Services, funding for the Health Action Zones (HAZs) was disbanded earlier than planned and the HAZs were “not able to demonstrate a measurable impact on health and wellbeing outcomes in their communities” (Department of Health and Human Services, 2012).

The National Evaluation of the HAZs published in 1999, lists the following as themes addressed in the evaluation of the HAZs (Judge, et al., 1999):

- Improving health and reducing health inequalities
- Restructuring and integrating services for improved health outcomes
- Securing improved value for money from all available resources
- Building and sustaining partnerships
- Involving and empowering local communities to achieve sustainable development
- Exploiting freedoms available to HAZs, forging innovation, bringing together policy and implementation and influencing central policy development.
Review of similar initiatives
Frameworks for building healthy cities and communities

The evaluation report also outlines eight health indicators (Judge, et al., 1999):

- Per cent who assess health as not good
- Per cent with limiting longstanding illness
- Per cent who smoke
- Per cent with high GHQ scores
- Per cent of births <2500 grams
- Infant mortality rate
- Under age conceptions per 1000 women age 13-15
- SMR all age all causes
- Standardised mortality ratio.

The report states that “the way in which different HAZs have specified the anticipated outcomes of their programs and activities varies enormously” (Judge, et al., 1999). The HAZs articulated their outcomes as outcome statements which the evaluators categorised into three levels:

1. The statement in the plan clearly sets out all of the information required to ascertain if the outcome change is successfully achieved
2. The statement does focus on an outcome change that could be assessed, but insufficient information is supplied in the plan to know if the change is successfully achieved
3. It is very unclear how the achievement of the outcome will be identified, assessed or measured (adapted from Judge, et al., 1999).

Examples of HAZ outcome statements by level (adapted from Judge et al., 1999):

<table>
<thead>
<tr>
<th>Level</th>
<th>Selected Example Population Health and Wellbeing Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Reduce gap in all causes age-standardised years of potential life lost between x and x</td>
</tr>
<tr>
<td></td>
<td>Reduce perinatal mortality rate from x to x</td>
</tr>
<tr>
<td></td>
<td>Reduce the different between the HAZ and other areas average heart disease rate by x</td>
</tr>
<tr>
<td>2</td>
<td>Reduce deaths from coronary heart disease and stroke in people under 65 in x to the level of the best similar inner city area</td>
</tr>
<tr>
<td></td>
<td>Reduced rate of teenage pregnancy across the city</td>
</tr>
<tr>
<td>3</td>
<td>Improved quality of life for older people (social, leisure, housing, transport and access, community safety and the environment)</td>
</tr>
<tr>
<td></td>
<td>By x, an improved sense of wellbeing amongst young people</td>
</tr>
</tbody>
</table>

The Ontario Healthy Communities Approach

In 1988, a national project was established with funding from Health and Welfare Canada called Healthy Communities in Canada. The decision was made to diverge from the WHO Healthy Cities model and use the term communities instead of cities. The Healthy Communities approach is now promoted by the Ontario Healthy Communities Coalition (OHCC), an incorporated registered charity established in 1992.

The OHCC supports local and regional groups, coalitions and networks that are working on Healthy Community initiatives in Ontario, Canada (Ontario Healthy Communities Coalition, ND).
The OHCC describe the Healthy Communities approach as being non-prescriptive and having a strong focus on community mobilisation (Sasseville & Martineau, 2012).

Ontario Healthy Communities outcome areas (Sasseville & Martineau, 2012):

<table>
<thead>
<tr>
<th>Target for change</th>
<th>Summary of Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>Skills and behaviour</td>
</tr>
<tr>
<td></td>
<td>Social participation</td>
</tr>
<tr>
<td></td>
<td>Lifestyle</td>
</tr>
<tr>
<td></td>
<td>Knowledge</td>
</tr>
<tr>
<td></td>
<td>Health status</td>
</tr>
<tr>
<td>Organisation</td>
<td>Participation</td>
</tr>
<tr>
<td></td>
<td>Skills development</td>
</tr>
<tr>
<td></td>
<td>Critical knowledge</td>
</tr>
<tr>
<td></td>
<td>Communication</td>
</tr>
<tr>
<td></td>
<td>Recognition</td>
</tr>
<tr>
<td></td>
<td>Provision/access to services</td>
</tr>
<tr>
<td>Community</td>
<td>Governance</td>
</tr>
<tr>
<td></td>
<td>Social</td>
</tr>
<tr>
<td></td>
<td>Economy</td>
</tr>
<tr>
<td></td>
<td>Culture</td>
</tr>
<tr>
<td></td>
<td>Environment</td>
</tr>
<tr>
<td></td>
<td>Healthy public policy</td>
</tr>
<tr>
<td></td>
<td>Resilience</td>
</tr>
<tr>
<td></td>
<td>Social inclusion</td>
</tr>
<tr>
<td>Regional/provincial/national</td>
<td>Governance</td>
</tr>
<tr>
<td></td>
<td>Legislation</td>
</tr>
<tr>
<td></td>
<td>Programs</td>
</tr>
<tr>
<td></td>
<td>Healthy public policies</td>
</tr>
</tbody>
</table>

Healthy Together Victoria

Healthy Together Victoria (HTV) is a state-wide prevention program adopting a dynamic systems approach to understanding complex system as the causes of public health issues affecting Victorians. HTV is a partnership between the Australian and Victorian Governments. HTV adopts a coordinated prevention effort across 14 Victorian LGAs (State Government of Victoria, 2014).

Outcomes identified by the WHO Healthy Cities project framework

The HTV evaluation framework (State Government of Victoria, 2014) is based on identifying:

- Measures of population outputs; and
- Intermediate population outcomes providing indications of progress along influencing pathways and early impact at the population level.

The intermediate population outcomes referred to in the policy statement, Strengthening Victoria’s Prevention System (State Government of Victoria, 2014) are:

- Environments pathway
  - Healthy physical environments
  - Food systems factors
  - Healthy social environments
The domains and desired outcomes of the Go Goldfields initiative were:

- **Communication, Literacy and Numeracy:** Improved communication and literacy skills, opportunities and positive life experiences for children and their families;
- **Strong Communities:** Improved community connectedness for children, youth and families;
- **Strong and Safe Families:** A reduction in the incidence of notifications to Child Protection Services (meaning a reduction in notifications, re-notifications and out of home care) involving families from the Central Goldfields Shire; and
- **Youth Employment:** Improving youth connection to appropriate training and education to achieve employment outcomes.

The Go Goldfields initiative approach encompassed:

- The partnership and governance processes and structures facilitated achievement of desired community outcomes;
- Community arts embedded in Go Goldfields work with children, youth and families;
- Shire-wide strategies developed and substantially implemented for children and families;
- The Go Goldfields’ flexible, place-based funding model delivered on desired community outcomes; and
- That there was strong alignment of Go Goldfields’ desired community outcomes and positions funded.

**Go Goldfields**

Go Goldfields is an extension of a piece of work undertaken by the Central Goldfields Shire Council, Victoria, Australia, called Gold Prospects (2008) (Central Victorian Primary Care Partnership, 2015). A set of shire-wide strategies were developed and agreed upon by the Go Goldfields Alliance corresponding to a set of desirable community outcomes.
Review of similar initiatives
Evaluations of similar health promotion initiatives

Evaluation of WHO Healthy Cities

The establishment and growth of the Healthy Cities Network is commonly referred to as Phases I to V and it has been acknowledged that there have been “substantial weaknesses in previous evaluations” of the Healthy Cities movement (de Leeuw, 2013). In reviewing the evaluations to date, de Leeuw (2013) advocates for a realist approach to evaluation and proposes the following questions for evaluating impact:

• To what extent can a specific (net) impact be attributed to the intervention?
• Did the intervention make a difference?
• How has the intervention made a difference?
• Will the intervention work elsewhere?

Healthy Cities (WHO) Network Phase V evaluation

The WHO summary report of the findings of the Phase V (2009-2013) evaluation (World Health Organisation, 2014) contains a summary of very high level findings which read like learnings rather than outcomes. These findings can be summarised as:

• European healthy cities contribute to values-based urban health development;
• Health equity is the fundamental value guiding healthy cities’ policies and programs;
• Health in all policies has provided a strategic framework for strategies and action programs;
• Health impact assessment gives a sharper focus to the inputs and multiple benefits of health urban planning and design;
• Innovative neighbourhood planning should grow organically, adopting then adapting citywide frameworks for social and physical regeneration;
• Cities have developed policy and program frameworks to guide action on health and equity; and
• Confounding factors pose difficulty in attributing effects to certain healthy city interventions.

Evaluation of Healthy Cities Noarlunga

The Healthy Cities approach was piloted in Australia in the Healthy Cities Noarlunga project, commencing in 1987. Evaluation data was collected throughout the project. Baum and Cooke (1992) reported outcomes in each of the following areas:

• Built healthy public policy
  • Involving government agencies, non-government organisations and other sectors in the development of local health policies and actions
• Addressing inequalities in health status
• Created supportive environments
  • Development of plans to address landscaping and tree planting needs in the local region
• Improving river water quality
Review of similar initiatives
Evaluations of similar health promotion initiatives

- Developing infrastructure to improve drinking water quality
- Improving school environments
- Strengthened community action
  - Increasing community awareness of the social determinants of health
  - To facilitate and support community participation and action on social health issues of local relevance
  - Community participation in the management of the project
- Developed personal skills
  - Individuals acquiring skills to: take an active role in community action; build effective relationships; be able to manage their own health; using professionals only when appropriate
- Reorientated health services toward prevention of illness and health promotion
  - Health worker commitment to the Healthy Cities program (adapted from Baum & Cooke, 1992).

Achievements were attributed to listening to the voice of community and taking advantage of and harnessing the “political issues of the time” (Baum & Cooke, 1992).

Evaluation of Health Action Zones

A centrally commissioned evaluation of the HAZ program began in 1999 (Barnes, et al., 2005).

The aim of the evaluation was to “identify and assess the conditions in which strategies to build capacity for local collaboration resulted in the adoption of change mechanisms that led to modernisation of services and a reduction in health inequalities” (Barnes, et al., 2005).

The evaluation turned out to be a challenging and complex process due to the establishment of 26 HAZs said to have been helping 13 million people (Judge, et al., 1999).

The report of the national evaluation states that “the way in which different HAZs have specified the anticipated outcomes of their programs and activities varies enormously” (Judge, et al., 1999).

The report notes a number of common problems in HAZs’ identification of anticipated outcomes, such as failure to specify:

- What the starting point is
- The scale of change aspired to
- The end point
- The specific groups or areas concerned.
Review of similar initiatives
Evaluations of similar health promotion initiatives

The report did however include some ‘good examples of HAZ planning’ (Judge, et al., 1999). These included the following features:

- The HAZ had an overall vision statement or clear plan
- These plans included a logical pathway from vision to themes, objectives and targets
- Clear statements of what success would look like at time points in the future were included
- Projects were described in detail along with outlines of what is expected/hoped for by short, medium and long term time points.

Reviews of the Healthy Communities Initiatives in Canada

A 2012 Ontario Healthy Communities report details a range of case studies from Healthy Communities initiatives across Canada and lists the following benefits observed across the initiatives (Sasseville & Martineau, 2012).

- **Individuals:**
  - Adoption of healthy lifestyle habits
  - Increase in physical activity, greater participation in activities offered, better use of athletic facilities
  - Improvement of dietary habits
  - Residents claim to be better informed about and aware of health and wellbeing (extremely varied themes affecting several health determinants)

- **Collective:**
  - Presence of more health-related services, programs and activities in the communities
  - Sustainability of local resources and better use of them through sharing (more human, financial and material resources and services)
  - Community empowerment: ability of local participants to take responsibility for health and wellbeing
  - Strengthening of social capital (increase in volunteerism, better collaboration between organizations, etc.)
  - Strengthening of social cohesion (social ties, sense of belonging)
  - Presence of measures, such as local public policies, that harmonize local actions.

- **Organisational:**
  - Snowball effect of collaboration, cooperation and partnerships (better networking, better support between partners)
  - Increased involvement of local participants concerned with health and wellbeing
  - Better access to services related to health and wellbeing
  - Empowerment, the capacity for self-expression and decision-making; development of critical awareness, increase in self-esteem
  - Development and good use of individual skills
  - Individual responsibility for health and wellbeing
Review of similar initiatives

Evaluations of similar health promotion initiatives

- Development of expertise on health and wellbeing among participants in local groups
- Better knowledge of the local community
- Development of a common vision and language
- Development of ‘healthy reflexes’ by the partners involved
- Better consolidation of services offered in the region
- Change in organizational culture, resulting in a bottom-up, participatory and inclusive approach
- Recognition of and credibility for the HC committees and organizations.

A summary of the key findings are presented below:

- There is no agreed definition of inequity and no description of its determinants
- Achieving equity and reducing inequity are not explicit goals of HTV and are therefore easily lost and poorly monitored
- All equity outcomes rely on a strong universal platform for prevention, universal inputs, and equally supportive economic environments for health
- The HTV workforce has a clear understanding of the social determinants of health but there is less awareness that it is the distribution of the social determinants that is responsible for health inequities
- Concise data on local and state inequalities is fragmented and focuses primarily on risk behaviours
- Better use of data would strengthen a systems approach to reducing inequities in health
- Within each of the settings of the HTV initiative there are many interventions that focus on assisting individuals to make choices to change their individual behaviour
- There is a need to review and revise strategies to ‘fit’ the aspirations and needs of marginalised communities in particular
- There are many examples of activities being well adapted to local conditions
- Partnerships between community health, NGOs and local governments are among the most significant at local levels

Evaluations of Healthy Together Victoria

In searching for an evaluation(s) of HTV, we identified the following:

- Rapid equity focused impact assessment of HTV
- Evaluation of Healthy Together Mildura.

Rapid Equity Focused Impact Assessment of HTV

In 2014 the HTV reference group decided to initiate an equity focused health impact assessment (EFHIA) for the HTV initiative (Wise, et al., 2015).

Rather than an evaluation, this process was framed as an opportunity to describe and predict the likely impacts of HTV and recommend actions.
Review of similar initiatives
Evaluations of similar health promotion initiatives

- There is little focus on population groups that are marginalised and have poor links with mainstream social institutions (adapted from Wise, et al., 2015).

**Evaluation of Healthy Together Mildura**

The Healthy Together Mildura (HTM) initiative was evaluated using a developmental evaluation approach working with data collected between 2012 and 2016.

The HTM team propose that evaluation of a system thinking complexity approach to prevention should not just be about tangible measurable outcomes. The evaluation report provides insights into “how we have worked and why we have worked in the way we have” (Underhill, 2016). The HTM evaluation report identifies the following key evaluation questions:

- What do rapid feedback and initial results reveal about progress toward intended systems change?
- What have been the key learnings, adaptations and developments within our site?
- What has been developed to embed ‘systems thinking’ within our site?

The following findings were among the discussion points outlined in detail in the report:

- Partnerships at all levels have been instrumental in providing opportunities for prevention to be realised

- Development of quality leadership for chronic disease prevention was one of the building blocks for the initiative
- Relationships are the primary reason why a systems base approach to health prevention has worked well in Mildura
- Event logging became ‘significant practice captures’ which have been refined to become useful tools for monitoring and measuring engagement
- Informal and more structured system mapping exercises enabled relationship building and cross-pollination of local knowledge to develop
- Cluster meetings were an effective way of bringing people together
- Connections with the community have strengthened and trust has developed, meaning that communities now approach HTM for guidance (adapted from Underhill, 2016).

**Evaluation of Go Goldfields**

The Go Goldfields Alliance undertook an evaluation of the Go Goldfields program utilising key indicators of change against community outcomes (Central Victorian Primary Care Partnership, 2015). The evaluation report states that the team explored a range of ways to measure progress.

The report identifies that there was ‘mixed success’ in using the framework of indicators, suggesting that “many of the indicators have still been too long term to demonstrate any change and some of the data required has been difficult to acquire” (Central Victorian Primary Care Partnership, 2015).
The evaluation report cites the following strategic level questions guiding the evaluation:

- What parts of the past or current work can be taken into the new evaluation environment and still measure what we need to measure?
- Along the journey we have had to deal with authority, anxiety, ambivalence and ambiguity. How do we do this in a supportive environment so that we can get the most from people and to allow experts to say ‘I don’t know’?
- The alignment of the authorised environment with place based work is challenging in its own right, requiring paradigm shifts with players at all levels, departmental bureaucrats, service decision makers, middle managers and service provision staff and members of the community. How do we concurrently add ‘evaluation’ onto this in a meaningful way?
- Who, when and how do we use external expertise to assist in our design and implementation of evaluation for this work?

The evaluation report outlines the following key successes:

- Parents and early years service providers are more aware of the importance of early communication, literacy and numeracy skills. Many have incorporated these skills into their interactions with children;
- Community speech pathology has built the capacity of parents and early years service providers to detect issues early and to collaboratively manage these issues with professionals. This success has led to MDHS redeveloping its speech pathology services in line with an early years focussed approach. Less children are requiring speech pathology on entering school;
- Prep reading levels and measures of childhood development have somewhat improved, however data over subsequent years is needed in order to identify ongoing impacts of the work;
- Families have had increased opportunities to be involved in both social and capacity building activities. This has improved their social connections, confidence and skills in parenting;
- Recent work done to develop a sustainable community arts approach for the future will build on all platforms to continue to provide opportunities for children, youth and families to be connected through the arts. However work needs to continue to engage local artists to ensure the sustainability of this approach;
- Family and early years service providers are demonstrating an increased commitment to working together to achieve Go Goldfields outcomes, including formalising common approaches and developing plans to collaboratively service the community;
Review of similar initiatives
Evaluations of similar health promotion initiatives

• Engaging with community groups or community champions to drive the work has been a significant step in achieving enduring community cultural change;

• Dedicated, flexible funding is needed to achieve meaningful community change. Without the $2.5 million from the Victorian Government, the Go Goldfields work would not have progressed substantially. Flexible funding has added the capacity to be responsive to emerging needs as they unfold; and

• Although in some cases the work has been at a developmental stage and may seem to be slow to progress, the progress made to build relationships and work towards common understandings has been considerable and created a strong and necessary foundation for future success (adapted from (Central Victorian Primary Care Partnership, 2015)).
Appendix C: Community survey
A community survey may include the following components:

1. **Demographic information**
   - Age?
   - Sex?
   - Town?
   - Member of a hard to reach group?
   - Role within community? – i.e. Health Champion, Assembly member, health service provider

2. **Community awareness**
   - Have you heard about the initiative?*
   - Do you know what the initiative is meant to do?

3. **Community involvement**
   - Have you been involved in the initiative? How?
   - Do you know how you can get involved?

4. **Impact area 1**
   - What is important to you in terms of health and wellbeing in Latrobe?
   - Is the initiative doing a good job? Can you give any examples?
   - Is the initiative not doing a good job? Can you give any examples?
   - How could the initiative do better? (per impact area)

5. **Impact area 2**

6. **Impact area 3**

7. **Impact area 4**

8. **Pace of change**
   - Is the initiative doing things too quickly? too slowly? somewhere in between?

9. **Innovation and evidence-base**
   - Do you know how the initiative decides to do things?

10. **Other feedback**
    - Is there anything else you would like to say about the initiative?

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*Initiative refers to the Latrobe Health Innovation Zone, Latrobe Health Assembly and the Latrobe Health Advocate interchangeably.
Appendix D:
Semi-structured interview guide
A semi-structured interview guide may include the following components

<table>
<thead>
<tr>
<th>ID</th>
<th>Topic</th>
<th>Questions</th>
</tr>
</thead>
</table>
| 1  | Demographic information        | Age?  
Sex?  
Town?  
Member of a hard to reach group?  
Role within community? – i.e. Health Champion, Assembly member, health service provider |
| 2  | Community awareness            | • Have you heard about the initiative*?  
• Do you know what the initiative is meant to do?                                           |
| 3  | Community involvement          | • Have you been involved in the initiative? How?  
• Do you know how you can get involved?                                                        |
| 4  | Impact area 1                  | • What is important to you in terms of health and wellbeing in Latrobe?  
• Is the initiative doing a good job? Can you give any examples?  
• Is the initiative not doing a good job? Can you give any examples?  
• How could the initiative do better?                                                          |
| 5  | Impact area 2                  | (per impact area)                                                                             |
| 6  | Impact area 3                  |                                                                                               |
| 7  | Impact area 4                  |                                                                                               |
| 8  | Pace of change                 | Is the initiative doing things too quickly? too slowly? somewhere in between?                  |
| 9  | Innovation and evidence-base   | Do you know how the initiative decides to do things?                                            |
| 10 | Other feedback                 | Is there anything else you would like to say about the initiative?                             |

*Initiative refers to the Latrobe Health Innovation Zone, Latrobe Health Assembly and the Latrobe Health Advocate interchangeably.
Appendix E: References
References


References


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