GIPPSLAND PRIMARY HEALTH NETWORK

Evaluation of the Latrobe Health Innovation Zone Early Detection and Screening Including Tobacco Initiative

FINAL REPORT

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Report by Healthcare Management Advisors and Larter Consulting

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The Latrobe Health Innovation Zone (LHIZ) Early Detection and Screening including Tobacco Initiative (the Initiative) was funded by the Victorian Government as an initiative of the Latrobe Health Innovation Zone. The initiative was coordinated by Gippsland Primary Health Network (PHN) and governed by the Project Control Group (PCG).

Gippsland PHN, HMA and Larter Consulting also acknowledge the PCG and all the stakeholders involved in the LHIZ Initiative. In particular we acknowledge the Collaborative Evaluation and Research Group (CERG) Federation University Gippsland which undertook many LHIZ Initiative evaluative activities.

ABBREVIATIONS

AIHW	Australian Institute of Health and Welfare
BMI	body mass index
BSV	BreastScreen Victoria
CATI	Computer assisted telephone interview
CCV	Cancer Council Victoria
CERG	Collaborative Evaluation and Research Group
Collaborative, the	Latrobe Cancer Screening Collaborative
DHHS	Department of Health and Human Services
DoH	Department of Health
GP	General Practitioner
GWH	Gippsland Women's Health
LCHS	Latrobe Community Health Service
LGA	Local Government Area
LGBTIQ+	Lesbian, Gay, Bisexual, Trans and gender diverse, Intersex, Queer and questioning
LHA	Latrobe Health Assembly
LHIZ	Latrobe Health Innovation Zone
LRH	Latrobe Regional Hospital
LSSS	Latrobe Smoking Support Service
MBS	Medicare Benefit Schedule
NAIDOC Week	National Aborigines and Islanders Day Observance Committee Week
NBCSP	National Bowel Cancer Screening Program
NRT	Nicotine Replacement Therapy
PBS	Pharmaceutical Benefit Schedule
PCG	Project Control Group
PCP	Primary Care Partnership
PDSA	Plan, do, study, act
PHN	Primary Health Network
PIP	Practice Incentive Program
QI	Quality Improvement
RACGP	Royal Australian College of General Practitioners
SA	Statistical Area
VACCHO	Victorian Aboriginal Community Controlled Health Organisation
VPHS	Victorian Population Health Survey

EXECUTIVE SUMMARY

BACKGROUND

The Hazelwood Mine fire in 2014 brought the health of the Latrobe Valley into the spotlight. The inquiry into the fire set out nine key deliverables related to early detection and screening including smoking cessation that formed the scope of the Latrobe Health Innovation Zone (LHIZ) Early Detection and Screening including Tobacco Initiative (the Initiative) activities.

In 2017, Gippsland Primary Health Network (PHN) was commissioned by the Department of Health and Human Services (DHHS) (now the Victorian Department of Health (DoH)) to support the implementation of activities under the Initiative under three themes:

(1) Smoking Cessation
(2) Population-based Cancer Screening (Breast, Bowel and Cervical), and
(3) Risk Assessment and Opportunistic Screening.

Project activities were both community facing and health system facing. The overall aim of the Initiative was to support people to prevent illness before it occurs, detect illness early and make sure that those who need treatment and support services can access them locally. The initiative was implemented using the concept of community co-design to ensure a community voice, and under the guidance of a Project Control Group (PCG) comprising local service providers, subject matter experts, and other relevant stakeholders.

META-EVALUATION

This meta-evaluation was based on the LHIZ Initiative Evaluation Framework program logic and evaluation questions. The evaluation was conducted as a desktop process using documentation and data collected during the Initiative by Gippsland PHN or commissioned service providers, or publicly available data sources. New data were not able to be collected as part of this meta-evaluation.

To assess the overarching evaluation aims, the evaluation was considered under five key evaluation areas, as follows:

(1) **Impact**: The project contributed to longer term impact level outcomes or project goal.
(2) **Effectiveness**: Short and medium-term project outcomes were achieved.
(3) **Efficiency**: Project inputs were efficiently translated to produce project outputs.
(4) **Appropriateness**: Project design was appropriate for the target population and context.
(5) **Sustainability**: Project results contributed to sustainable capacity with funding or policy support.

The overarching evaluation questions for the Initiative were:

(1) How has the co-design process enhanced development of program initiatives and program outcomes?
(2) What system redesign changes have occurred, who has benefited and are they sustainable?
(3) Have smoking rates decreased, cancer screening rates increased (bowel, breast and cervical) and opportunistic screening rates increased?
(4) Have community attitudes towards lifestyle modifications to improve overall health and wellbeing improved? Has this resulted in behaviour change?

OVERARCHING EVALUATION QUESTIONS

Co-design process

Activities under the Initiative engaged well with community to understand community perspectives on enablers and barriers regarding smoking cessation, cancer screening and risk and opportunistic screening. There was a strong response to community priorities identified with feedback used to develop new models of care for trial as well as tackle community awareness and understanding, and system issues such as lack of GP availability. For the most part, activities / projects that were co-designed with community had good participation rates. In comparison, projects that used tailored off-the-shelf products were less successful. However, more work to engage people from at risk or vulnerable population groups could be undertaken in future to ensure needs or barriers unique to these groups are addressed.

It is also important to acknowledge the time required to appropriately engage the community in a co-design process for new models of care. Consultation and re-consultation times are required before a model of care can be finalised, time is then required to establish the project and if necessary, recruit staff and participants before the project is implemented.

System re-design

The aim of the Initiative was to generate synergistic achievements through collaboration and united goals, inter-agency approaches, and activities tailored to the needs of local community. Across all three themes of the Initiative, projects were undertaken that focused on engaging the community, as well as projects that sought to engage health professionals and system re-design. However, an overarching approach that linked health system and community facing activities together was not applied. This was reflected in the omission of a dedicated planning phase for the overarching concept of the Initiative, which saw early activities / projects delivered without community consultation and often with poorer results.

Activities within the Initiative approached each of the three themes separately despite the crossover of the target audiences (both in the community facing and in the health system). There are system issues that present barriers common to all three themes such as awareness of services and suitable referral processes, collection and analysis of data to identify at risk individuals, and overdue reminder processes. Establishing processes to tackle common barriers that can be applied to multiple themes will reduce duplication of effort. Similarly, community consultation identified many common barriers across themes such as fear of results, perceived low value of screening and lack of incentive.

Ensuring sustainable system re-design requires engagement of local health system stakeholders. Fostering a collective approach to tackling a common issue to progress mutual objectives will be more successful than each party working independently and can reduce duplication of effort and resources. This requires a consistent data collection and shared data access to drive the desired changes. The PCG provided strong support from statewide agencies, but local engagement was comparatively lacking. As a result, integration of processes between components of the health system were not maximised.

Embedding quality improvement processes takes time and requires ongoing support and resources for health professionals to implement. Uptake of training and education offered to health professionals was overall lower than anticipated. Further investigation into the reasons for low uptake is required to improve activities in future.

There are learnings / activities from individual projects that will be maintained beyond the Initiative. However, limited data to determine if projects were value for money combined with lack of sustainable funding options hindered the establishment of new models of care into routine business practices.

Rates of smoking, cancer screening and opportunistic screening

Data from the Victorian Population Health Surveys did not detect any significant population level change in adult daily smoking prevalence between 2017 and 2020. It is important to note this survey is not powered to detect changes in prevalence

of health behaviours at an LGA level that could be expected over this period and arising from a community-based initiative.

Analysis of cancer screening program participation data showed there had been little change to cancer screening participation rates at a population level in Latrobe between 2016-17 and 2020-21.

Many of the Initiative activities / programs commenced from 2019 onwards and are unlikely to have demonstrated any impact by 2020 / 2021. Additional data are needed to fully understand potential impacts of the Initiative on smoking and cancer screening rates.

Further analysis of cervical smear PIP claims from general practice showed a substantial increase in cervical smear rates in 2021–22 in Latrobe compared to Gippsland and Australia, suggesting the Initiative activities contributed to this rise, which will impact on subsequently reported cervical cancer screening rates in the area.

Smoking status of patients was captured well by GPs in Latrobe and Gippsland, with the smoking status unknown for less than 15% of patients at the commencement of the Initiative. However, other health measures are less well recorded by GPs. Recording of alcohol consumption improved but there was little change to the recording of other patient health metrics by GPs during the Initiative. Additional information is required to understand the full impact of the Initiative on GP behaviour regarding opportunistic screening.

Education activities relating to referral processes for Quitline and the Life! program correlated with increased referrals to these services but waned during periods with no corresponding education / training. This suggests an ongoing need for education or prompts to maintain behaviour change among health professionals (at least in the short to medium term).

Community attitudes

The Initiative included a good mix of activity types undertaken across all three themes and they engaged good numbers of the Latrobe community. Social media was a wide-reaching medium especially when cross promoted by relevant stakeholders and therefore was an effective way to promote campaign messaging.

Further information on behaviour change within the community is required to assess the reach and impact of the social marketing campaigns.

Despite numerous projects within the cancer screening theme that focused on Aboriginal and Torres Strait Islander people, more work could be done to target vulnerable population groups including culturally and linguistically diverse people and LGBTIQ+ people, especially for smoking cessation and opportunistic screening themes.

SUMMARY OF FINDINGS AND RECOMMENDATIONS

Table ES1 on the following page provides a list of the findings and recommendations per key evaluation area.

EXECUTIVE SUMMARY

Table ES1: Summary of evaluation findings and recommendations by key evaluation area

FINDINGS	RECOMMENDATIONS
Impact	
(1) Statistically significant changes in daily smoking rates in Latrobe adults were not observed between 2017 and 2020 and were always unlikely given the power of the available survey data. (2) The Initiative did not significantly affect bowel screening rates in Latrobe between 2017 and 2020. However, additional data are required to assess the full impact of activities of the Initiative that were delivered between 2019 and 2022. (3) The Initiative did not significantly affect breast screening rates in Latrobe between 2017 and 2020. However, additional data are required to assess the full impact of Initiative activities that were delivered between 2019 and 2022. (4) Latrobe exceeded the aim of increasing breast cancer screening rates for women aged 70–74 up to the state average in 2018–19. (5) The analysis indicated breast screening rates for women residing in Moe, Morwell and Churchill were relatively unchanged between 2016-18 and 2017-19. (6) The analysis indicated that the Initiative contributed to a substantial increase in cervical smear rates in general practice in 2021–22 compared to previous years. However insufficient data were available at the time of evaluation to determine if the increased cervical smear rates reported corresponds to a similar increase in cervical screening rates. Additional data are required to assess the full impact of activities of the Initiative that were delivered between 2019 and 2022. (7) Smoking status of patients was captured well by GPs in Latrobe and Gippsland, with the smoking status unknown for less than 15% of patients. (8) Recording of alcohol consumption in general practice patient management systems was the only opportunistic screening metric to demonstrate a positive trend (decrease) in the proportion of 'unknown' status during the Initiative. (9) COVID-19 is likely to have impacted opportunistic screening by GPs for most metrics, possibly except for alcohol consumption. (10) Increased referrals from health professionals to Quitline corresponded to times when health professional education / training on smoking cessation was undertaken but waned during periods with no corresponding education / training. The proportion of Quitline callers using NRT increased significantly from baseline to 2021. The trends were observed in Latrobe, Baw Baw, and more broadly across Gippsland, reflecting the inclusion of the Gippsland region in training / education initiatives.	1. Collect and analyse additional smoking and cancer screening data for 2021 onwards (and for specified target groups such as bowel screening rates for men in the postcodes of Moe and Morwell), to determine the full impacts of the Initiative. 2. Collect and analyse primary care data for 2022 onwards, and re-survey GPs about opportunistic screening behaviours. 3. Consider and plan for recurrent education / prompts in future activities targeting behaviour change among health professionals.

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FINDINGS	RECOMMENDATIONS
(11) Initial increases in referrals to Life! from GPs were not maintained in the long-term suggesting that ongoing activities and prompts are required to create lasting behaviour change. (12) Targeting other health professionals/facilitators/providers for referrals to the Life! program may be more sustainable than targeting only GPs.	
Effectiveness	
(13) There was a good mix of the types of activities undertaken to engage community members including online, social media, written reminders and in person clinics. The Initiative activities were able to reach and engage large numbers of the community of Latrobe (and surrounding areas), albeit this was still only a small proportion of the total population of Latrobe (over 77,000 people as at the 2021 census[1]). (14) Multiple media campaigns were used through the Initiative to promote activities. These focused largely on cancer screening, followed by smoking cessation. Only one campaign focused on risk assessment / opportunistic screening, which occurred late in the Initiative timeframe (2021). (15) Social media was the most used type of media for campaigns under the Initiative. (16) Social media can be wide-reaching within the community and can therefore be an effective way to promote campaign messaging. However, it is recognised that not all community members engage with this media type. (17) The cancer screening theme included activities that focused on Aboriginal and Torres Strait Islander people and, to a lesser extent, culturally and linguistically diverse people and the LGBTIQ+ community. (18) Activities / projects that specifically targeted vulnerable people were successful, while non-targeted programs showed very low participation rates from vulnerable population groups. (19) There was no information to assess the effect of Initiative activities on consumer attitude and behaviour. (20) There were mixed results relating to uptake of education and training activities by health professionals. (21) Except for the Latrobe Cancer Screening Collaborative which supported general practices to complete 'plan, do, study, act' cycles of quality improvement, there was low completion of quality improvement activities among general practice.	4. In future initiatives, seek information from the community on the reach of the social marketing campaigns and their effectiveness, to inform decisions regarding the value for money of state initiatives. 5. Future initiatives should include dedicated programs for vulnerable population groups. 6. System re-design occurs slowly and requires ongoing supports and training. Future projects need to allow enough time for processes to be embedded as routine practice to ensure ongoing sustainability. 7. Behaviour change is a slow process and individuals will vary in starting points as well as time required. Future projects should allow enough time / funding for medium-to-longer term effects to be observed. If this is to be combined with community co-design approaches, seven to 10 years may be a more suitable timeframe for expected behaviour changes to be observed. 8. Continue to provide opportunities for further training on preventative care for general practice such as standards, data optimisation, and MBS items.

[1] https://abs.gov.au/census/find-census-data/quickstats/2021/LGA23810

EXECUTIVE SUMMARY

FINDINGS	RECOMMENDATIONS
(22) HealthPathways were developed on appropriate topics with input from clinicians and subject matter experts. (23) *Cervical cancer* and *weight management, nutrition and physical activity* were the most sought after HealthPathways developed, demonstrating the need for clinical and referral pathway information among health professionals in Gippsland for these categories. (24) The Collaborative demonstrated positive effects on cancer screening rates in participating general practices arising from process changes, but improvements in population level screening rates were not observed. (25) Maintaining robust general practice data collection and cleansing processes were considered critical aspects of the quality improvement process and necessary for future sustainability of the program. (26) Nurse-led clinics were positively received, but the sustainability of this model will depend on identifying suitable funding models. (27) Models of care co-designed with the community showed good participation and satisfaction rates. However, there were insufficient data to demonstrate they resulted in beneficial patient outcomes or improved system processes in the longer-term.	
Efficiency	
(28) Activities and projects under the Initiative addressed a good proportion of the themes and barriers raised by members of the Latrobe community during consultation. Projects consistently addressed issues relating to *raising awareness*, *increasing access* and *increasing health professional engagement* across all three focus areas: smoking cessation, cancer screening and opportunistic screening. (29) The PCG fulfilled its terms of reference regarding governance and accountability. However, opportunities to support greater impact from the Initiative through local and inter-agency / multi-focused collaborations were missed. (30) Tension between PCG members on the balance between evidence and innovation may have reduced the potential impact of Initiative activities. (31) The POLAR dashboard (and alternate algorithm) has potential to be shared more broadly with general practices across Gippsland, to enable practices to routinely review their own data for quality improvement. (32) The cost of the Initiative was $4.4 million over five and a half years. This equated to an average cost per activity / project of approximately $64,000.	9. Future co-design projects need to allow for multiple rounds of input from community members and health professionals. Projects should allow for lead in time for co-design processes. 10. In future, exploration into mechanisms to enable the PCG (or similar group) to drive local influence need to be explored. This could be through greater local stakeholder engagement with groups like the PCG or consideration of using a collective impact approach to generate local buy-in. 11. In future, an even balance of subject matter experts, local healthcare providers and community representatives is required for advisory and control groups. 12. Future programs need to ensure that requisite data for monitoring and evaluation purposes is available. Where appropriate, lag time for public data availability should be factored into evaluation timeframes.

EXECUTIVE SUMMARY

FINDINGS	RECOMMENDATIONS
(33) The largest cost category was staff salaries and wages at 40% of total costs, with the remaining 60% spent on the three themes of the Initiative (approximately 20% per theme). (34) There was a mix of implementation activities on which Initiative funding was spent, with close to 40% being spent on *building systems and capability / capacity* over the life of the Initiative.	
Appropriateness	
(35) The PCG membership had a good mix of relevant organisations. Further engagement with additional local service providers may have been beneficial, especially organisations for Aboriginal and Torres Strait Islander people and culturally and linguistically diverse people. (36) There was ample opportunity for PCG members to be informed and to contribute to the Initiative, especially during the developmental stages in the first 18 months of the project. (37) During COVID, the PCG meetings continued (predominately via teleconference), providing opportunities for collaboration and consultation during this time. (38) Engagement of PCG members varied by organisation, although the majority (75%) of members attended more than 60% of PCG meetings. (39) Further clarity on the role/s of the PCG would have assisted group operations and enhanced the effectiveness of the group overall. (40) The PCG appropriately provided governance and accountability for the Initiative, however clearer Terms of Reference may have helped respond to evolving expectations of members. (41) PCG membership felt that many PCG suggestions and feedback were acted upon with due consideration. (42) Community engagement to co-design Initiative projects was undertaken using mixed methods including face to face workshops / focus groups, verbal and written surveys, in person or telephone interviews and vox pops. (43) Aside from the Opportunistic Screening consultation process, there was limited community engagement with vulnerable populations groups (such as Aboriginal and Torres Strait Islander people or culturally and linguistically diverse people) to identify any specific needs or barriers. (44) The Initiative sought community input to tailor activities to the needs / circumstances of the local community. However, additional follow-up with community members could	13. Future undertakings in this space need to allow adequate planning time to ensure identified barriers are approached from both the community and health system perspectives for synergy and greater potential impact. 14. Future programs should investigate suitable mechanisms to include cross promotion between themes and apply system-wide redesign approaches across multiple themes where appropriate.

EXECUTIVE SUMMARY

FINDINGS	RECOMMENDATIONS
have been undertaken to ensure designed projects would be acceptable within the community, and that implementation of interventions was progressing appropriately. There was no information to assess the effectiveness of the promotional activities of the Initiative. (45) The Initiative offered limited training programs for health professionals outside of general practice.	
Sustainability	
(46) There are learnings / activities from individual projects that will be maintained beyond the Initiative. However, larger scale systemic changes were not observed. New models of care were not established with sustainable funding models, making it difficult to continue once the Initiative funding ceased. Lack of community data on the impact of awareness raising campaigns such as behaviour change hinders assessment on whether programs are worth continued investment. Lack of project cost data or cost-benefit analysis for most activities prevents any robust assessment on the value of projects undertaken under the Initiative. (47) The Collaborative model was considered useful to bring about change in a clinical setting, but this was dependant on funding support for clinics to participate in intensive quality improvement activities. (48) Lessons from the Collaborative project can be used to support ongoing activities to embed quality improvement in general practice. (49) Two of the key strengths and enablers of the Initiative were the administration through Gippsland PHN, and the alignment with broader national primary healthcare reforms. In addition, creation of data dashboards, software optimisation and use of automated campaigns for lapsed screeners provide a foundation for future ongoing activity. (50) The main barriers to sustainability for projects under the Initiative were a lack of demonstration of value for money and lack of sustainable funding models identified. This may be due to lack of clarity in project design and objectives. Health workforce turnover is another challenge that requires ongoing education / training initiatives to be maintained.	15. In future, consideration to sustainable funding models needs to be embedded into new models of care to ensure sustainability if proven successful. 16. Continue to provide ongoing support to general practice regarding quality improvement processes.

1 INTRODUCTION

1.1 BACKGROUND

In June 2016, the Victorian Government released the '*Hazelwood Mine Fire Inquiry: Victorian Government Implementation Plan*', setting out 246 actions to implement all recommendations and affirmations of the 2014 and 2015/16 Mine Fire Inquiry Reports. The '*Hazelwood Mine Fire Inquiry: Victorian Government Implementation Plan*' highlighted that the Government will work collaboratively with the Latrobe Valley community to improve health and wellbeing outcomes of residents, with specific actions to:

- designate Latrobe Valley as the Latrobe Valley Health Zone
- establish a Latrobe Valley Assembly to promote, support and oversee the development of the Latrobe Valley Health Zone
- appoint a Health Advocate
- engage with the community to identify local health priorities, and
- support and fund the development and delivery of health improvement strategies to address health priorities.

'Health in the Latrobe Valley' is a key response area within the 'Hazelwood Mine Fire Inquiry: Victorian Government Implementation Plan' supported by 68 dedicated Deliverables. The Latrobe local government area was designated as a Health Innovation Zone, with the Latrobe Health Assembly established to bring a stronger community-led approach to the commissioning of health improvement programs in the area.

1.1.1 Initiative scope

There are nine key deliverables from the Hazelwood Mine Fire Inquiry (Deliverables 69 – 77) related to early detection and screening including smoking cessation, as follows:

- Deliverable 69: Review current population and opportunistic screening rates, practices and services in the Latrobe Valley
- Deliverable 70: In consultation with the community and other relevant stakeholders, develop a plan for implementing a system-wide approach to encourage health professionals to ask patients about their smoking and offer support to quit
- Deliverable 71: Implement the smoking cessation initiative, in partnership with the Latrobe Health Assembly, the community and other stakeholders
- Deliverable 72: Based on the outcomes of the review of population screening rates, practices and services, develop a strategy and implementation plan to improve access to screening services for vulnerable and high-risk groups
- Deliverable 73: Based on the outcomes of the review of opportunistic screening rates, practices and services, support the Latrobe Health Assembly to develop a strategy and implementation plan to improve access to opportunistic screening and early intervention services for identified priority areas
- Deliverable 74: Support the Latrobe Health Assembly to commence a trial of integrated screening and assessment approaches for chronic disease
- Deliverable 75: Promote, and increase the use of, existing primary care systems to assist healthcare providers to identify clients for screening
- Deliverable 76: Partner with providers across the Latrobe Valley's health system to develop and implement recruitment and health promotion strategies to encourage community participation in available health screening opportunities
- Deliverable 77: Embed the smoking cessation initiative, in partnership with key service providers.

These deliverables form the scope of the Latrobe Health Innovation Zone (LHIZ) Early Detection and Screening including Tobacco Initiative activities and this meta-evaluation.

In 2017, Gippsland Primary Health Network (PHN) was appointed by the Department of Health and Human Services (DHHS) (now the Victorian

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Department of Health (DoH)) to support the implementation of activities related to Deliverables 69-77. The Latrobe Health Assembly had a partner role in supporting and advising the implementation approach and associated budget within the broader LHIZ to help agencies achieve the best outcomes for the local community.

The LHIZ Early Detection and Screening including Tobacco Initiative (the Initiative) encompassed three project areas:

(1) Smoking Cessation
(2) Population-based Cancer Screening (Breast, Bowel and Cervical), and
(3) Risk Assessment and Opportunistic Screening.

Project activities were both community facing and health system facing.

1.1.2 Initiative aim

The overall aim of the Initiative was to support people to prevent illness before it occurs, detect illness early and make sure that those who need treatment and support services can access them locally.

1.1.3 Co-design concept

The Initiative was implemented using the concept of community co-design:

> *'Co-design offers opportunities for positive change that starts with people and communities in a ground-up approach. It works to find out how to support people and communities to meet their needs within the realities of their lives.'*
>
> *'It is underpinned by understandings that community members have the knowledge and means to create solutions to challenges or problems they experience… Co-design is a partnership approach that enables 'users' or 'clients' to actively define and shape strategies and outcomes.'* [2]

1.2 INITIATIVE GOVERNANCE

The Initiative was governed by a Project Control Group (PCG) that comprised key stakeholders from relevant peak bodies and departmental agencies as follows:

- DHHS / DoH
- Gippsland PHN
- Latrobe Regional Hospital
- Latrobe Community Health Service
- Cancer Council Victoria
- Breast Screen Victoria
- QUIT Victoria
- Victorian Chronic Disease Primary Alliance
- Latrobe Health Assembly
- Latrobe City Council
- Latrobe Community Representative, and
- Gippsland Women's Health

The terms of reference for the PCG included:

- providing advice
- monitoring project progress and delivery
- endorsing project management documentation
- escalation point for change approval and issue management
- providing advice and guidance on engagement with the Latrobe Health Assembly, and
- receiving recommendations on potential investments to achieve project objectives.

[2] Latrobe Health and Wellbeing Charter, Victorian Department of Health and Human Services. Page 7. https://www.healthassembly.org.au/wp-content/uploads/2021/02/Latrobe-Health-and-Wellbeing-Charter.pdf

1.3 AIMS OF THE OUTCOMES EVALUATION

The outcomes evaluation of the Initiative was designed to assess:

- effectiveness and impact of the Initiative and activities undertaken
- efficiency and sustainability of the Initiative and activities undertaken, and
- appropriateness of the Initiative.

1.4 EVALUATION METHOD

This meta-evaluation was based on the LHIZ Initiative Evaluation Framework program logic and evaluation questions. The evaluation was conducted as a desktop process using documentation and data collected during the Initiative by Gippsland PHN or commissioned service providers, or publicly available data sources. New data were not able to be collected as part of this meta-evaluation. The following information has been used to inform the evaluation:

- LHIZ Initiative evaluation framework
- Community consultation reports
- Project reports from LHIZ activities
- Facebook and YouTube 'views' data
- POLAR data from participating general practices
- HealthPathways analytic data
- LHIZ acquittal information
- Australian Institute of Health and Welfare (AIHW) cancer screening data, and
- Victorian Population Health Survey data on smoking rates.

A full list of data and documentation included in the meta-evaluation is provided at Appendix A.

1.4.1 Evaluation rubric

An evaluation rubric was developed to rate observed changes in quantitative data. The evaluation rubric is provided in Appendix B.

1.4.2 Limitations of the evaluation

The LHIZ Initiative evaluation framework proposed a mixed-method approach to the meta-evaluation. However, many of the planned data collection activities were not implemented during the Initiative[3], limiting the data available for evaluation purposes. Therefore, there are limitations to the assessment of the impacts of the initiative and the robustness of conclusions that can be drawn. A comparison of planned and available data for evaluative purposes is provided in Appendix C.

1.5 PURPOSE OF THIS DOCUMENT

This document is the final report of the outcomes evaluation for the Initiative. It assesses the Initiative against the key evaluation areas with recommendations for future development. The remainder of the report is structured as follows:

- Part A: Context
  - Situation analysis
  - Evaluation framework
- Part B: Evaluation findings
  - Impact
  - Effectiveness
  - Sustainability
  - Efficiency
  - Appropriateness
  - Discussion

[3] The COVID-19 pandemic impacted elements of the project.

PART A CONTEXT

2 SITUATION ANALYSIS

2.1 LATROBE CHARACTERISTICS

Latrobe City is a Local Government Area (LGA) situated in Gippsland Victoria, approximately 150 kilometres east of Melbourne. It comprises four central towns: Churchill, Moe/Newborough, Morwell and Traralgon; and smaller rural townships of Boolarra, Glengarry, Toongabbie, Tyers, Traralgon South, Yallourn North and Yinnar. The population of Latrobe at the 2021 census was 77,318 people with a median age of 42 years, and one fifth of the population (21.1%) aged over 65 years (notably higher than Victoria at 16.8%)[4].

The traditional owners of the land are the Brayakaulung clan of the Gunaikurnai people. Two percent of the population in Latrobe identify as Aboriginal and Torres Strait Islander (double that of Victoria at 1%). Eight percent of people in Latrobe were born in a non-English speaking country (substantially less than for Victoria at 24%). A greater proportion of people in Latrobe experience very high disadvantage (28% compared to 15% in Gippsland and 10% in Australia)[4] [5].

Latrobe Valley is a Statistical Area Level 3 (SA3), which overlaps (almost entirely) with Latrobe City and includes the same towns and townships. The population of Latrobe Valley at the 2021 census was 77, 168 people[6].

For the purposes of this evaluation Latrobe City and Latrobe Valley can be considered to refer to the same location/population known as Latrobe throughout this report.

Industry in Latrobe has traditionally been the electricity industry, with several brown coal mines and power stations including the Hazelwood coal mine (which closed in 2017). In 2014, a fire burned in the Hazelwood mine for 45 days. The Latrobe Health Assembly and the LHIZ Initiative were developed in response to the impacts of the fire on the health of the community. Other industry in Latrobe include forestry, farming and food processing, engineering, and tertiary education (Federation University Australia).

2.1.1 Summary of key health statistics

At the time the LHIZ Initiative commenced (2016), Latrobe had poor health statistics for smoking rates, cancer screening rates and other chronic conditions, as summarised below.

Smoking

- Gippsland had the highest smoking prevalence of all Victorian regions (20%) while in Latrobe City 24% of adults smoked daily or occasionally. The local smoking rates were significantly higher than the Victorian prevalence of 13%[7].
- While a substantial proportion of people living in Gippsland have stopped smoking (26%), the proportion of people who are ex-smokers in Latrobe City (23%) is one of the lowest in Victoria[7].
- Referral rates for people seeking support and advice to specialist services such as Quitline from health professionals in Latrobe City are the lowest in Victoria.
- The proportion of people who have never smoked in Latrobe City (52%) is significantly lower than the state average (62%), reflecting higher youth uptake in communities in which many adults smoke[7].

[4] Australian Bureau of Statistics, 2021 Census All persons QuickStats: Latrobe (Vic.) LGA
[5] Gippsland PHN Health Needs Snapshot: Latrobe Local Government Area 2022.
[6] Australian Bureau of Statistics, 2021 Census All persons QuickStats: Latrobe Valley (SA3)
[7] Victorian Population Health Survey 2014: Quick stats at local government area: Latrobe

Cancer screening

Bowel and breast cancer screening participation rates in Latrobe were generally higher than the Victorian rate (for bowel among both males and females), while cervical cancer screening rates in Latrobe were below the Victorian rates.

Bowel cancer participation rates in Latrobe were lower for[8]:

- males
- 50 year olds (compared to 55, 60, 65 or 70 year olds), and
- residents of the Moe and Morwell Statistical Area Level 2 (SA2), compared to the rest of Latrobe.

Breast cancer screening rates in Latrobe were lower for[9]:

- women aged 70-74 years (compared to women aged 50-69 years)
- women in Moe, Morwell and Churchill postcodes compared to the rest of Latrobe, and
- Aboriginal and Torres Strait Islander women and women who speak a language other than English at home.

Cervical cancer screening rates in Latrobe were lower among[10]:

- 20-24 year olds, and
- 65-69 year olds.

Chronic disease

Based on information from the 2014 Victorian population health survey[11], people in Latrobe were more likely to:

- be obese (22.0%) compared to Victoria (18.8%)
- have high blood pressure (37.1%) compared to Victoria (25.9%)
- have at least one chronic disease (52.7%) compared to Victoria (47.1%), and
- have two chronic diseases (16.6%) compared to Victoria (11.1%).

2.2 LHIZ EARLY DETECTION AND SCREENING INCLUDING TOBACCO OBJECTIVES

The overall project aim was to support people to prevent illness before it occurs, detect illness early and make sure that those who need treatment and support services, including smoking cessation, can access them locally.

To achieve the above aim, both health system facing and community facing initiatives were implemented. Implementation activities continued until March 2022. The objectives for the three project areas (or themes) are listed below.

2.2.1 Smoking Cessation Objectives

(1) Co-develop a plan, with the community or community representatives, to engage other groups and sectors to increase quitting and decrease smoking uptake.
(2) Increase community knowledge of smoking risk and services that support quitting in Latrobe.
(3) Increase the provision of best practice and evidence-based care to the community by:
   (a) Increasing health professionals' skills, confidence and knowledge in smoking cessation through engagement, education and quality improvement activities.
   (b) Redesigning clinical practice and environments in general practices, hospitals, dental practices, community health services and other primary care clinics.
   (c) Increasing community and social service professionals' skills, confidence and knowledge in providing smoking cessation advice through engagement and education.
   (d) Redesigning environments and screening practices in community and social service organisations.

[8] AIHW. National bowel cancer screening program, monitoring report, 2016
[9] BreastScreen Australia monitoring report 2013-2014, published by AIHW, 2016
[10] AIHW, Cervical screening in Australia 2013-14
[11] Victorian Population Health Survey 2014: Quick stats at local government area: Latrobe

(4) Improve patient screening and data recording practices in general practice, hospitals, community health services and other primary care to evaluate the short and long-term impacts of systems changes, particularly among priority population groups.

2.2.2 Population Based Cancer Screening Objectives

(1) Identify gaps in population-based bowel, breast and cervical cancer screening practice (processes, systems, referral pathways, follow up care and support) among health professionals including general practitioners and practice staff
(2) Establish a local governance model supporting population-based cancer screening programs in Latrobe.
(3) Implement system improvements for follow up on positive results and timely access to local specialists and interventional services.
(4) Improve sustainable population-based bowel, breast and cervical cancer screening practice (processes, systems, referral pathways, follow up care and support) among health professionals including general practitioners and practice staff.
(5) Increase whole of community awareness of population-based bowel, breast and cervical screening programs.
(6) Increase breast cancer screening rates for eligible Aboriginal and Torres Strait Islander women and women who speak a language other English at home to the state average.
(7) Increase breast cancer screening rates for women aged 50 -74 years living in Churchill, Moe and Morwell to the state average.
(8) Increase bowel cancer screening rates for men aged 50 living in Latrobe to the state average.

2.2.3 Risk Assessment and Opportunistic Screening Objectives

(1) Implement the Integrated Risk Assessment Tool (The Health Check).
(2) Undertake a whole of system analysis for risk assessment and opportunistic screening and support services in Latrobe.
(3) Improve the provision of evidence based health assessment and screening care to the community.

2.3 OTHER LHIZ AND BROADER INITIATIVES

The Early Detection and Screening including Tobacco Initiative project is one component of several programs put in place to improve the health and wellbeing of the people of Latrobe.

The Latrobe Health Assembly (LHA) is responsible for the coordination of a new era of community engagement, health improvement and integration of health and community services for people with complex conditions. The LHA offers the community a chance to drive health and wellbeing priorities with a focus on innovative ideas and approaches and a vision of 10,000 more people with better health and wellbeing in 10 years.

The Latrobe Health Advocate aims to provide a trusted and independent voice for Latrobe communities engaging with them to prioritise health and wellbeing and influencing economic development projects to ensure they contribute to a healthier community and do not adversely affect community health.

The Inspector General for Emergency Management is responsible for monitoring and reporting on the progress of all recommendations and affirmations from the 2014 and 2015-16 Inquiry reports. The *Hazelwood Mine Fire Inquiry Implementation of recommendations and affirmations Annual Report 2018* commended the timeliness of implementation noting that 211 of the 246 actions set out in the Victorian Government Implementation Plan are now complete and 6 of the 14 recommendations and affirmations directed to health agencies are also complete. In addition to health initiatives, work has been done in the areas of incident air quality and wellbeing, coal mine regulation, mine site rehabilitation and emergency management planning, response and recovery.

2.4 LHIZ INITIATIVE PROJECTS AND TIMELINES

The following activities or projects were implemented under the LHIZ Initiative.

Overarching

Project type	Project / Activity	When
Health System Online Portal for Health Practitioners	HealthPathways	2017-2021
Health System: Data Analysis	Evaluation Dashboard Indicators (POLAR)	2020-2021
Community: Social dynamics	Social Network Analysis	2020

Smoking cessation

Project type	Project / Activity	When
Community: Consultation	Smoke-Free Innovation Workshops	2018
Community: Consultation	Qualitative Research with Latrobe Valley Smokers	2019
Community: Consultation	Latrobe Community Health Service Smoking Clinic Community Consultations	2020
Community: Campaign	Pitch to Quit Competition	2018 and 2021
Community: Event	Community Quit Victoria Stalls	2017
Health System and Community Campaign	Pharmacy Smoking Cessation Project	2021
Health System and Community Intervention	Latrobe Smoking Support Service	2021-22
Health System Health Practitioners: Education Sessions	Education Sessions for GP's and Practice Nurses	2017
Health System: General Practice Training/Incentive.	Smokefree Gippsland: Three Step Brief Intervention Model	2019-2020

Cancer screening

Project type	Project / Activity	When
Community: Consultation	Latrobe Health Assembly (LHA) Focus Groups: Breast Screening and Bowel Cancer Screening	2017
Community Consultation	Cervical Screen Survey, 2018	2018
Community Consultation	Consumer conversations about beliefs and attitudes to population-based cancer screening in Latrobe, Gippsland: Stage 1 – Vox Pops	2018
Community: Consultation	Qualitative Research on Cancer Screening	2019
Community: Survey	Cancer Screening Community Survey	2021
Community: Breast Screening Program	Gippsland Strategy (BSV)	2017
Community: Breast Screening Campaign	Improving Breast Screening Participation within Gippsland PHN (BSV)	2019-2020
Community: Education and Screening Event	Churchill BreastScreen Group Booking: Bust Trip	2018
Community: Education Event	The Gathering Place: Bowel Comedy	2018
Community: Cancer Screening Campaign	Screen For Me	2019 and 2021
Community: Education and Screening Event	Ramahyuck Cancer Screening Activities	2019

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Project type	Project / Activity	When
Community: Education Event	Screen For Me: Community Grants	2021
Health System: General Practitioner Training	Cancer Screening Collaborative	2019-2020
Health Practitioners and Community Cancer Screening Campaign	Screen For Me: Engaging General Practice	2021
Health System: Nurse Cervical Screening Training	Nurse Cervical Screening Training Program	2019 and 2021

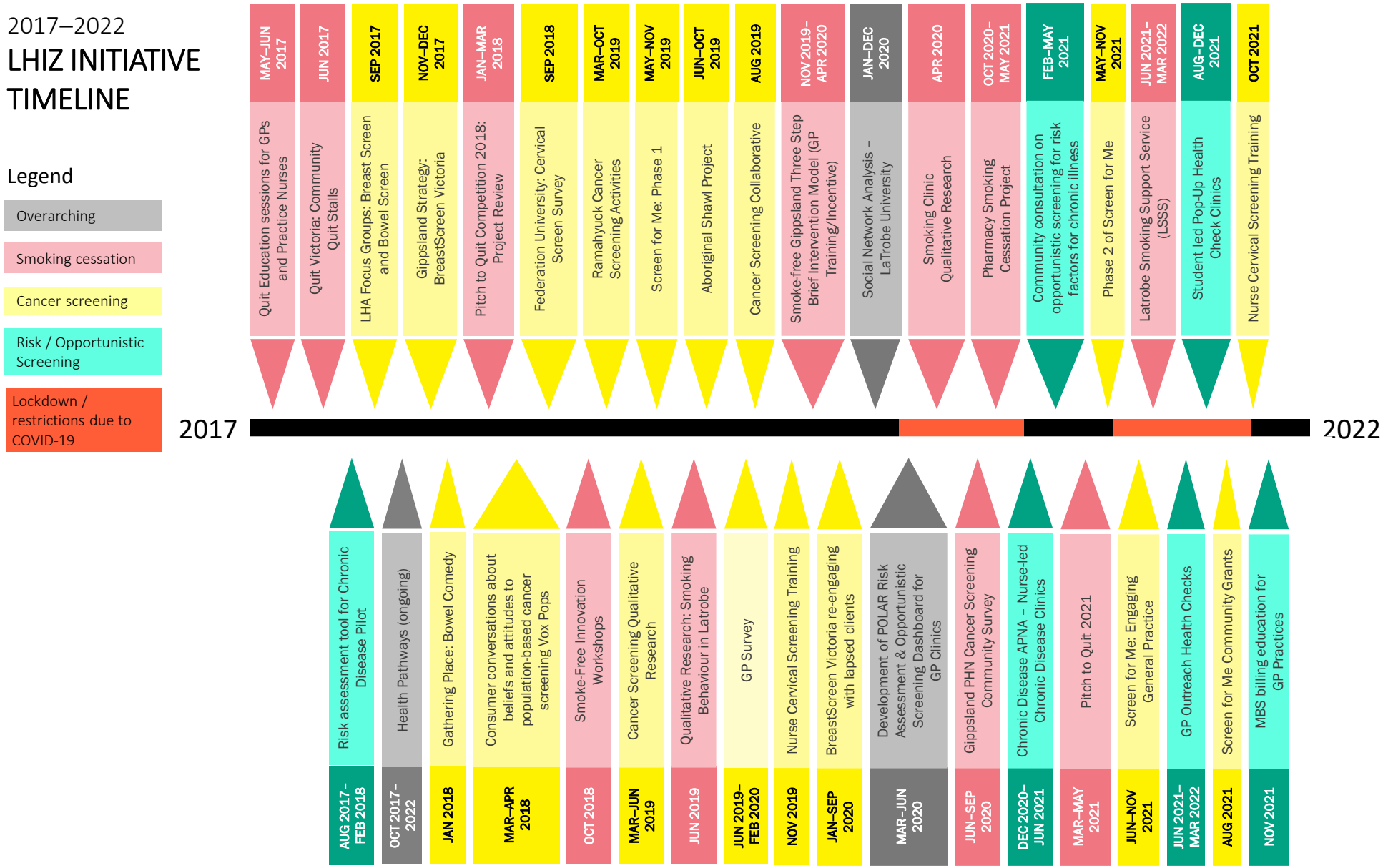
Risk and opportunistic screening

Project type	Report Title and Author	When
Community: Consultation	Community Survey	2020
Community: Consultation	Community Consultation on Opportunistic Screening for Risk Factors for Chronic Illness	2021
Community: Risk assessment Tool	Pilot of the Integrated Risk Assessment Tool for Chronic Disease	2017-2018
Community: Student Led Pop-Up Health Check Clinics	Student Led Pop-Up Health Check Clinics	2021
Community: GP Outreach Health Checks	General Practice Outreach Health Checks	2021-2022
Health System: Survey: Health Professionals	Survey of General Practitioners	2019
Health System and Community: Establishment of Nurse Led Clinics	Supporting the Establishment of Nurse Led Clinics for Risk Prevention Project	2020-2021
Health System: Training for GPs in MBS billing opportunities	MBS billing opportunity training to improve opportunistic screening for chronic conditions	2021

A timeline of activities is diagrammatically presented on the following page.

2 SITUATION ANALYSIS

2017–2022 LHIZ INITIATIVE TIMELINE



3 EVALUATION FRAMEWORK

3.1 OVERARCHING AIM OF THE META-EVALUATION

The meta-evaluation of the Initiative sought to address four overarching evaluation questions, as follows:

(1) How has the co-design process enhanced development of program initiatives and program outcomes?
(2) What system redesign changes have occurred, who has benefited and are they sustainable?
(3) Have smoking rates decreased, cancer screening rates increased (bowel, breast and cervical) and opportunistic screening rates increased?
(4) Have community attitudes towards lifestyle modifications to improve overall health and wellbeing improved? Has this resulted in behaviour change?

3.2 KEY EVALUATION AREAS

To assess the overarching evaluation aims, the evaluation was considered under five key evaluation areas, as follows:

(1) **Impact**: The project contributed to longer term impact level outcomes or project goal.
(2) **Effectiveness**: Short and medium-term project outcomes were achieved.
(3) **Efficiency**: Project inputs were efficiently translated to produce project outputs.
(4) **Appropriateness**: Project design was appropriate for the target population and context.
(5) **Sustainability**: Project results contributed to sustainable capacity with funding or policy support.

3.3 PROGRAM PILLARS

The evaluation and associated questions were considered across the three program pillars:

- **Partnership development and stakeholder liaison,** including partnership and networking, consumer engagement, and facilities and equipment.
- **Building system capability and capacity and health system improvement,** including networking and collaboration, clinical and referral pathways, quality improvement, service access, service redesign, modification and integration, and new and/or innovative service models and solutions.
- **Building knowledge through education,** including health provider training and education, community support, public education, marketing and health promotion, and access to services.

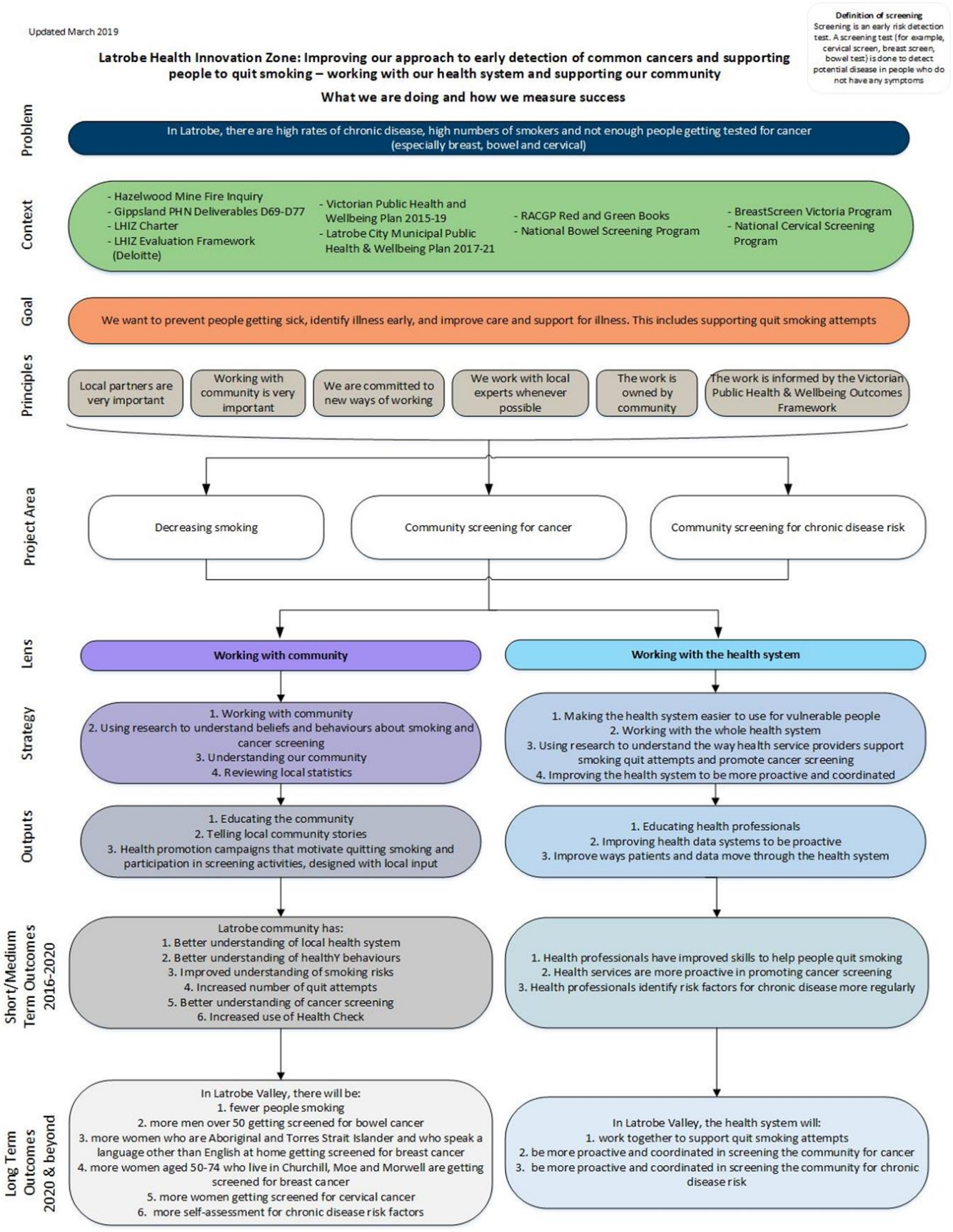
3.4 PROGRAM LOGIC

A program logic for the Initiative was prepared to support development of the evaluation questions and methodology (provided in Figure 3.1 and Figure 3.2 and on the following pages).

Detailed evaluation questions are provided in Part B of this report which addressed the individual evaluation areas.

3 EVALUATION FRAMEWORK

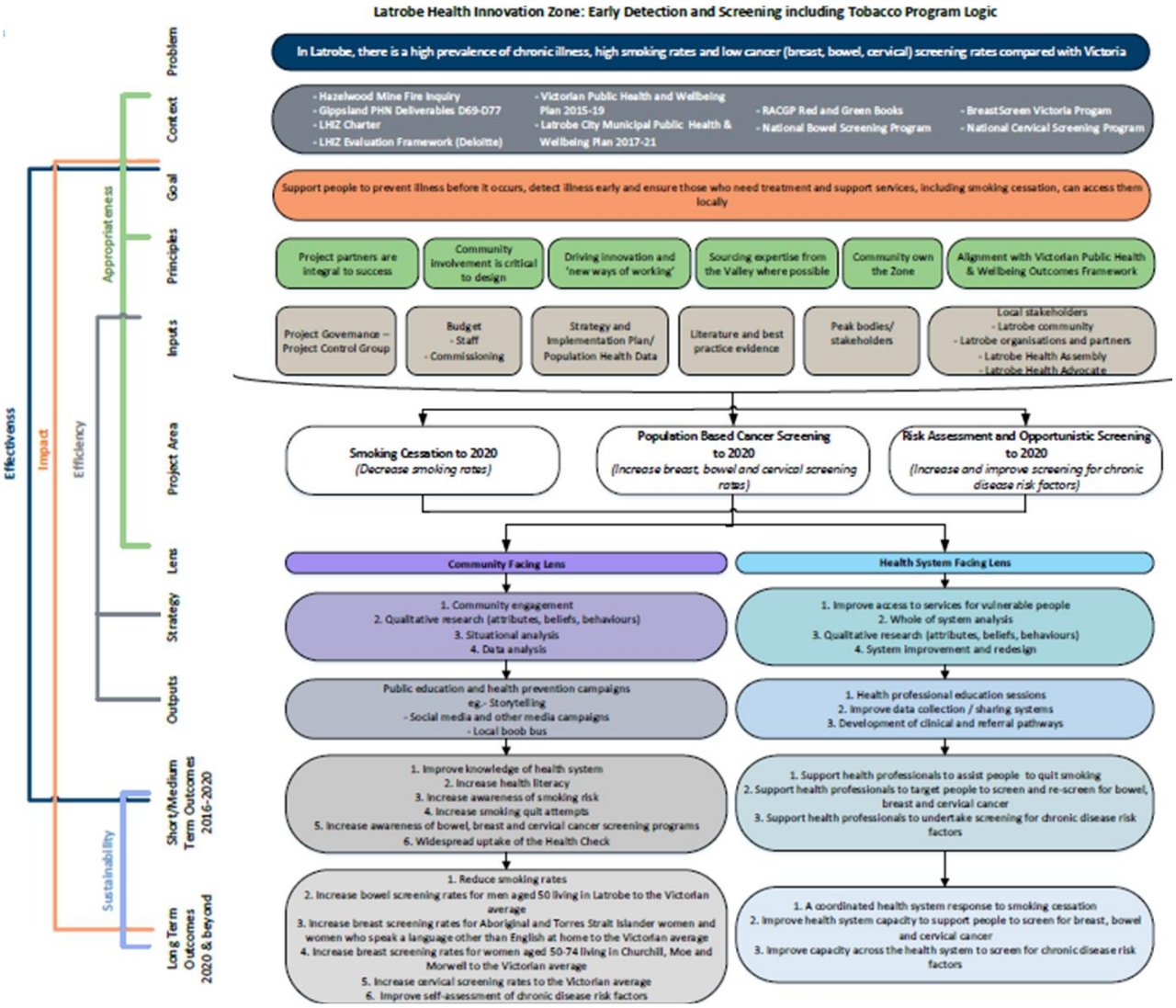
Figure 3.1: LHIZ Initiative program logic – general public version



Source: LHIZ Early Detection and Screening Including Tobacco Initiative Evaluation Framework

3 EVALUATION FRAMEWORK

Figure 3.2: LHIZ Initiative program logic – detailed version



Source: LHIZ Early Detection and Screening Including Tobacco Initiative Evaluation Framework

PART B EVALUATION FINDINGS

4 IMPACT

4.1 SUMMARY

Analysis of population health data up to 2020-2021 showed there had been little change to overall smoking rates or cancer screening rates in Latrobe compared to baseline figures in 2016-17. However, many of the Initiative activities / programs commenced from 2019 onwards and are unlikely to have demonstrated any impact by 2020-2021. Additional data is needed to fully understand potential impacts of the Initiative on smoking and cancer screening rates. An analysis of cervical smear PIP claims from general practice showed a substantial increase in cervical smear rates in 2021–22 in Latrobe compared to Gippsland and Australia, suggesting the Initiative activities contributed to this rise, which will impact on subsequently reported cervical cancer screening rates in the area.

Analysis of available information demonstrated that there had been little change to the recording of patient health metrics by GPs during the Initiative except for alcohol consumption. However, additional information now that COVID-19 pandemic measures have ceased is required to understand the full impact of the Initiative on GP behaviour regarding opportunistic screening.

Meanwhile, education activities relating to referral processes for Quitline and the Life! program correlated with increased referrals to these services but waned during periods with no corresponding education / training. This demonstrates an ongoing need for education or prompts to maintain behaviour change among health professionals (at least in the short to medium term).

4.2 EVALUATION QUESTIONS

The meta-evaluation sought to assess the impact of the Initiative on the expected long-term outcomes including reduced smoking and increased cancer screening rates, and improved health system processes to support health professionals assist clients. The key evaluation question was:

> *To what extent did the Initiative contribute to the longer-term impact level outcomes and goals?*

Detailed evaluation questions were:

Consumer facing

- What was the impact of the Initiative on the rates of smoking and cancer screening for people residing in Latrobe?
- What new or modified services were developed to support cancer screening and smoking cessation?

Health system facing

- Has there been an increase in confidence of health professionals for health screening?
- What was the impact on referrals to Quitline and to the Life! program?
- In what way has the Initiative strengthened the relationship between health professionals and Gippsland PHN in relation to supports for data collection and data sharing?

4.3 ANALYSIS AND FINDINGS

4.3.1 Smoking rates

The Initiative aimed to increase smoking cessation rates and decrease smoking uptake among residents of Latrobe comparative to baseline (pre-2017). To assess

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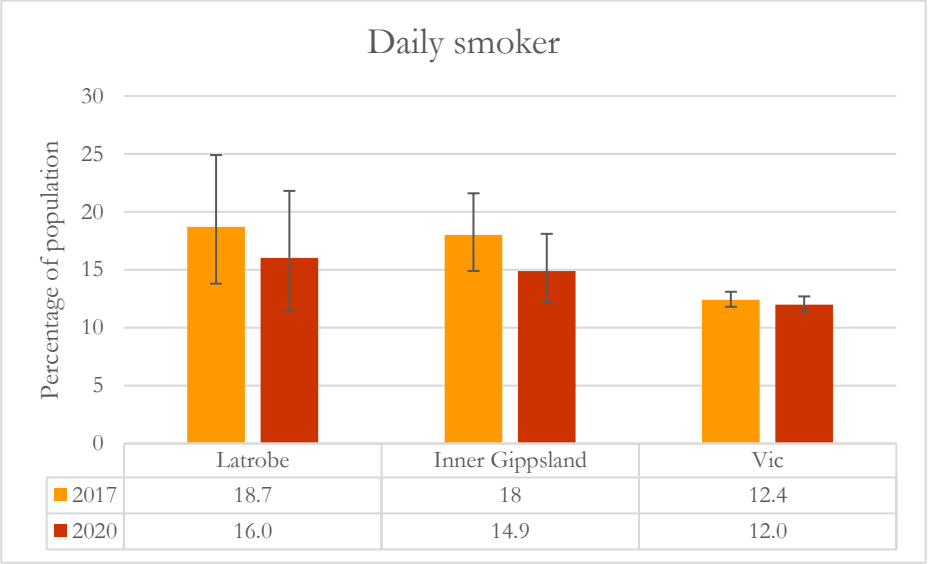
the impact of the Initiative on smoking, population smoking rates based on data from the Victorian Population Health Survey (VPHS) were analysed.

The VPHS reports on smoking rates for Victoria and sub-regional areas each year. Every three years the VPHS undertakes a survey of Victorians large enough to report on individual LGAs. This occurred in 2017 and 2020 and is scheduled to be undertaken again in 2023. Due to 2020 data collection occurring during the COVID-19 pandemic, results need to be interpreted with caution.

Daily smokers

Figure 4.1 shows daily smoking prevalence for adults in Latrobe, Inner Gippsland and Victoria in 2017 and 2020. While a reduction in the proportion of daily smokers is observed in Latrobe (18.7% in 2017 down to 16.0% in 2020), this change is not statistically significant as indicated by the overlapping 95% confidence intervals. It is important to note the VPHS is not powered to detect changes in prevalence of health behaviours at an LGA level that could be expected over this period and arising from a community-based initiative. It is positive however to observe the gap between the rates of daily smoking in Latrobe and Victoria becoming smaller.

Figure 4.1: Rates of daily smokers in 2017 and 2020, showing estimates with 95% confidence intervals



Source: VPHS dashboards for 2017 and 2020, available at https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey

Current and ex-smokers

Over the same time period, the rate of current smokers (defined as daily and occasional smokers) in Latrobe remained stable (21.6% in 2017 compared to 22.0% in 2020), as did the rates in Victoria as a whole (16.7% compared to 16.4%, respectively), see Figure 4.2. Changes in Inner Gippsland are not statistically significant.

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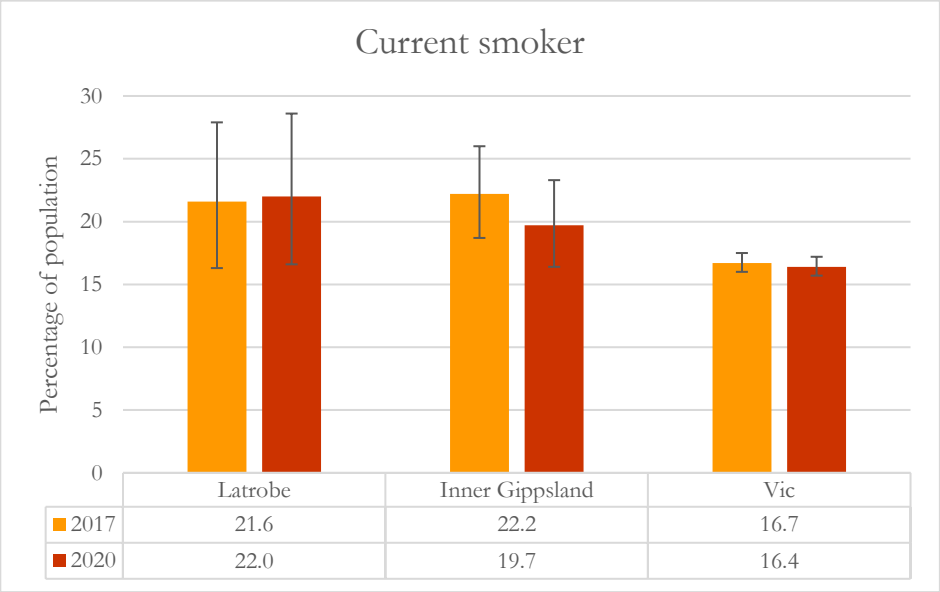
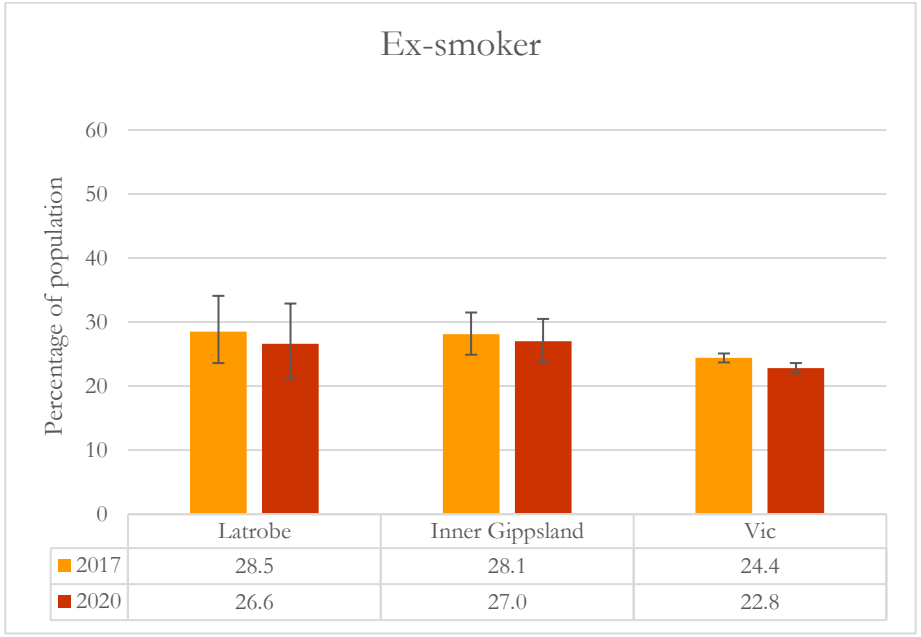
Figure 4.2: Rates of current smokers in 2017 and 2020, showing estimates with 95% confidence intervals



Source: VPHS dashboards for 2017 and 2020, available at https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey

A small decrease in the estimated proportion of ex-smokers in Latrobe and Inner Gippsland between 2017 and 2020 is suggested, as shown in Figure 4.3.

Figure 4.3: Rates of ex-smokers in 2017 and 2020, showing estimates with 95% confidence intervals



Source: VPHS dashboards for 2017 and 2020, available at https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey

Analysis of GP data on patient smoking status (based on POLAR data extracts) showed similar results with very little change between the proportion of patients indicating they were smokers or ex-smokers from 2017 to 2021, as illustrated in Figure 4.4 (although it must be noted that POLAR data are subject to variation as more GP practices commence using the data analysis software).

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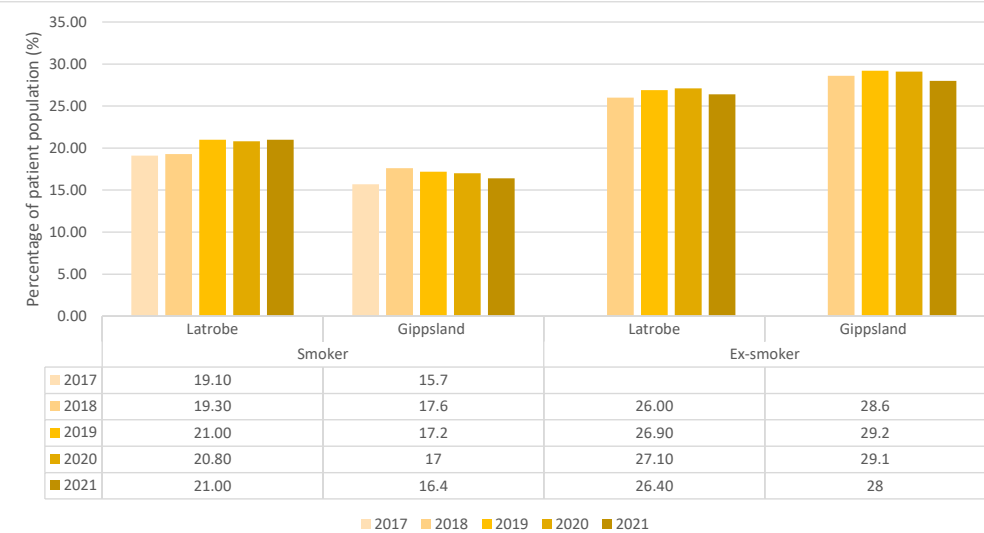
Figure 4.4: Rates of Smokers and Ex-smokers based on POLAR GP data



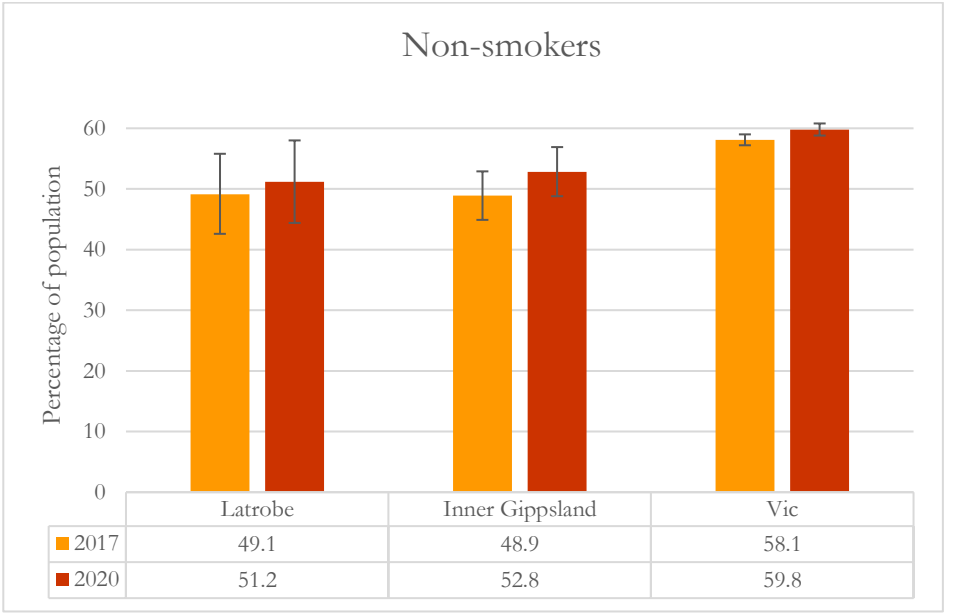
Source: POLAR data provided by Gippsland PHN

Non-smokers

As shown in Figure 4.5, the 2020 estimated rate of non-smokers in Latrobe (51.2%) was slightly higher compared to 2017 (49.1%), however the change is not statistically significant with the 95% confidence intervals overlapping. Rates of non-smokers in Inner Gippsland (defined as the LGAs of Bass Coast, Baw Baw, Latrobe and South Gippsland) and Victoria are also estimated to be higher in 2020. Both Latrobe and Inner Gippsland had a significantly lower rate of non-smokers compared to Victoria in 2017 and 2020.

Statistically significant changes to adult daily smoking prevalence were not detected in Latrobe, however it is important to note the VPHS is not powered to detect changes in prevalence of health behaviours at an LGA level that could be expected over this period and arising from a community-based initiative.

Figure 4.5: Rates of non-smokers in 2017 and 2020, showing estimates with 95% confidence intervals



Source: VPHS dashboards for 2017 and 2020, available at https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey

Available data cannot be used to determine if the Initiative contributed to a reduction in smoking among residents in Latrobe by 2020. It is likely that factors beyond the Initiative were also contributing to smoking rates during this time.

It should be noted that activity under the Initiative continued until December 2021. Therefore, the full impact of the Initiative may not be reflected in these data.

Finding 1: Statistically significant changes in daily smoking rates in Latrobe adults were not observed between 2017 and 2020 and were always unlikely given the power of the available survey data.

4.3.2 Cancer screening rates

Bowel cancer screening rates

Bowel cancer screening participation rates in Latrobe and Gippsland more broadly have historically been the same or higher than the Victorian rate. However, further analysis by age range, smaller geographies and sex showed areas for improvement in bowel cancer screening uptake, particularly for men aged 50–59 years of age, and for men in the postcodes of Moe and Morwell. Therefore, the Initiative aimed to increase bowel screening rates up to the state average for men aged 50–59 living in Latrobe.

Bowel cancer screening data were obtained from AIHW and the National Bowel Cancer Screening Program (NBCSP).

As shown in Table 4.1, analysis of AIHW bowel cancer screening data showed that compared to baseline in 2016-17 (46.8%), Latrobe demonstrated an increased bowel cancer screening rate for people aged 50–74 years each year until 2018–2019 (47.8%, an increase of 1.0 percentage points). The increase observed in Latrobe was just slightly below the increase observed in Gippsland (an increase of 1.4 percentage points), but less than Victoria (an increase of 2.8 percentage points) in the same period. The data also showed a drop in bowel cancer screening rates from 2018–19 to 2019–20 across all regions, presumably due to COVID-19 pandemic measures. The decrease continued in Latrobe and Gippsland in 2021–22 (44.5% and 47.3%, respectively), but the Victorian rates saw a small increase to 43.9% at this time. Despite this, the bowel cancer screening rates for Latrobe remained higher than the Victorian rates in 2020–21 (44.5% compared to 43.9%, respectively). The observed growth at the midway point was considered *acceptable* for Latrobe Valley and Gippsland as per the evaluation rubric (see Appendix B).

Table 4.1: Bowel screening rates for people aged 50–74 years of age from 2014–2015 to 2019–2020

Location	2016-17 Baseline (B)	2017-18		2018-19				2019-20		2020–21			
	Proportion people aged 50–74 (%)	Proportion people aged 50–74 (%)	Change from B (percent-age points)	Proportion people aged 50–74 (%)	Change from B (percent-age points)	Percent-age change from B (%)	Perform-ance rating	Proportion people aged 50–74 (%)	Change from B (percent-age points)	Proportion people aged 50–74 (%)	Change from B (percent-age points)	Percentage change from B (%)	Perform-ance rating
Latrobe Valley	46.8	47.6	0.8	47.8	1.0	2.2%	Acceptable	46.4	-0.4	44.5	-2.3	-4.9%	Very poor
Gippsland	49.3	50.4	1.1	50.7	1.4	2.9%	Acceptable	49.5	0.2	47.3	-2.0	-4.1%	Very poor
Vic	43.2	45.2	2.0	46.0	2.8	6.4%	Excellent	44.6	1.4	43.9	0.7	1.6%	Fair

Source AIHW Cancer Screening Programs Quarterly Data January 2023.

Performance rating based on the evaluation rubric as follows:
- Decrease from baseline = very poor
- No change (0–0.9 percentage points) = poor
- Increase of 1 to 1.9 percentage points = fair
- Increase of 2 to 2.9 percentage points = acceptable
- Increase of 3 to 3.9 percentage points = good
- Increase of 4 to 4.9 percentage pints = very good
- Increase of 5 or more percentage points = excellent.

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Further analysis of bowel cancer screening rates by sex and age was conducted for the 2016–17 to 2019–20 years, based on data from the NBCSP, see Tables 4.2 and 4.3. The analysis of bowel screening data for men aged 50–74 (Table 4.2) showed a similar trend to bowel screening rates for all people of the same age range, with screening rates for Latrobe and Gippsland remaining higher than rates for Victoria. The increased screening rates observed in Latrobe (an increase of 2.8 percentage points) was on par with the increase observed in Gippsland (an increase of 2.6 percentage points), but less than Victoria (an increase of 3.5 percentage points) in the same period. All growth was considered *excellent* as per the evaluation rubric (Appendix B). This was followed by a drop in bowel cancer screening rates between 2018-19 and 2019-20, resulting in a performance rating of *acceptable* in Latrobe, *fair* in Gippsland, and *excellent* in Victoria as per the evaluation rubric.

However, the analysis of bowel screening data for men aged 50–59 (Table 4.3) showed that in this age range, men in Latrobe (32.8%) were less likely to be screened for bowel cancer compared to Gippsland (37.0%), but on par with Victoria (33.0%) in 2016–17. There was a small increase in screening rates across regions between 2016–17 and 2018–19 (considered *excellent* as per the evaluation rubric), followed by a drop in screening rates in 2019-20. In 2019–20, Latrobe bowel cancer screening rates for men aged 50–59 years of age (33.2%) remained below the Victorian rate (34.5%), although the growth remained above baseline rates (considered *fair* as per the evaluation rubric).

Table 4.2: Bowel screening rates for men aged 50–74 years

Location	2016-17 (B)	2018-19				2019-20			
	Proportion of men aged 50–74 (%)	Proportion of men aged 50–74 (%)	Change from B (percentage points)	Percentage change from B (%)	Performance rating	Proportion of men aged 50–74 (%)	Change from B (percentage points)	Percentage change from B (%)	Performance rating
Latrobe	43.5	46.3	2.8	6.4%	Excellent	44.4	0.9	2.1%	Acceptable
Gippsland	47.3	49.9	2.6	5.5%	Excellent	48.2	0.9	1.9%	Fair
Vic	40.5	44.0	3.5	8.6%	Excellent	42.1	1.6	4.0%	Excellent

Source: NBCSP data, provided by Gippsland PHN. See evaluation rubric in Appendix B for performance ratings.

Table 4.3: Bowel screening rates for men aged 50–59 years

Location	2016-17 (B)	2018-19				2019-20			
	Proportion of men aged 50–59 (%)	Proportion of men aged 50–59 (%)	Change from B (percentage points)	Percentage change from B (%)	Performance rating	Proportion of men aged 50–59 (%)	Change from B (percentage points)	Percentage change from B (%)	Performance rating
Latrobe	32.8	35.4	2.6	7.9%	Excellent	33.2	0.4	1.2%	Fair
Gippsland	37.0	39.5	2.5	6.8%	Excellent	36.3	-0.7	-1.9%	Very poor
Vic	33.0	35.9	2.9	8.8%	Excellent	34.5	1.5	4.5%	Very good

Source: NBCSP data, provided by Gippsland PHN. See evaluation rubric in Appendix B for performance ratings.

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As at 2019-20, the observed increases in bowel screening rates in Latrobe corresponded to increases observed in Gippsland and Victoria. However, many of the cancer screening activities of the Initiative (e.g. Screen For Me) commenced in 2019, and therefore the impact of these would not be expected to be observed until 2020-21 or beyond. Additional data for subsequent years (2020-21, 2021-22, and 2022-23) are required (when available) to assess the full impact of the Initiative on bowel cancer screening rates for men in Latrobe.

Finding 2: The Initiative did not significantly affect bowel screening rates in Latrobe between 2017 and 2020. However, additional data are required to assess the full impact of activities of the Initiative that were delivered between 2019 and 2022.

Data on bowel screening rates for men in the postcodes of Moe and Morwell were not available for analysis.

Breast cancer screening rates

Breast cancer screening participation rates in Latrobe and Gippsland more broadly have historically been the same or higher than the Victorian rate. However, further analysis by age, smaller geography and vulnerable population groups showed areas for improvement in breast screening uptake. Therefore, the Initiative aimed to increase breast screening rates up to the state average for:

- women aged 70–74 in Latrobe
- eligible Aboriginal and Torres Strait Islander women in Latrobe
- eligible women who speak a language other than English in Latrobe, and
- women aged 50–74 years living in the post codes of Churchill, Moe and Morwell.

Breast cancer screening data was obtained from AIHW and BreastScreen Victoria.

As shown in Table 4.4, analysis of AIHW breast screening data showed that compared to baseline in 2016–2017 (58.3%), Latrobe demonstrated a small decrease in breast screening rates for women aged 50–74 years each year until 2018–2019 (57.9%, a decrease 0.4 percentage points). The decrease observed in Latrobe was on par with that observed in Gippsland (a decrease of 0.3 percentage points) and Victoria (a decrease of 0.6 percentage points) in the same period. However, there was a dramatic decrease in breast screening rates in Latrobe, Gippsland and Victoria between 2018–2019 and 2019–2020, due to cessation of breast screening services resulting from COVID-19 pandemic measures. All decreases in breast cancer screening rates were considered *very poor* as per the evaluation rubric (Appendix B).

Many of the cancer screening activities of the Initiative (e.g. Screen For Me) commenced in 2019, and therefore the impact of these would not be expected to be observed until 2020-21 or beyond. Additional data for subsequent years (2020-21, 2021-22, and 2022-23) are required (when available) to assess the full impact of the Initiative on breast cancer screening rates for women in Latrobe.

Finding 3: The Initiative did not significantly affect breast screening rates in Latrobe between 2017 and 2020. However, additional data are required to assess the full impact of activities of the Initiative that were delivered between 2019 and 2022.

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Table 4.4: Breast screening rates for women aged 50–74 years of age from 2016–2017 to 2019–2020

Location	2016–2017 Baseline (B)	2017–2018		2018–2019				2019–2020			
	Proportion women aged 50–74 (%)	**Proportion women aged 50–74 (%)**	**Change from B (percentage points)**	**Proportion women aged 50–74 (%)**	**Change from B (percentage points)**	**Percentage change from B (%)**	**Performance rating**	**Proportion women aged 50–74 (%)**	**Change from B (percentage points)**	**Percentage change from B (%)**	**Performance rating**
Latrobe Valley	58.3	57.4	-0.9	57.9	-0.4	-0.7%	Very poor	52.8	-5.5	-9.4%	Very poor
Gippsland	57.0	56.7	-0.3	56.7	-0.3	-0.5%	Very poor	51.8	-5.2	-9.1%	Very poor
Vic	54.1	54.1	0.0	53.5	-0.6	-1.0%	Very poor	46.1	-8.0	-14.7%	Very poor

Source AIHW Cancer Screening Programs Quarterly Data October 2022. See evaluation rubric in Appendix B for performance ratings.

Further examination of breast screening rates for women aged 70–74 years of age (Table 4.5) showed an increased screening rate for this age group in Latrobe, Gippsland and Victoria. The growth observed in Latrobe (increase of 3.7 percentage points from 2016–17 to 2018–19) was notably higher than Gippsland (2.9 percentage points growth) and Victoria (1.7 percentage points growth), resulting in Latrobe (61.1%) having a screening rate higher than both Gippsland (59.1%) and Victoria (54.2%) in 2018–2019 for women aged 70–74 years. Growth observed in Latrobe and Gippsland were both considered *excellent* as per the evaluation rubric (see Appendix B), while Victoria's growth was considered *good*.

Finding 4: Latrobe exceeded the aim of increasing breast cancer screening rates for women aged 70–74 up to the state average in 2018–19.

Data for 2019–2020 were not analysed as it is known that services were ceased due to COVID-19 pandemic measures in this period.

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Table 4.5: Breast screening rates for women aged 70–74 years

Location	2016–2017 Baseline (B)	2018–2019			
	Proportion women aged 70–74 (%)	**Proportion women aged 70–74 (%)**	**Change from B (percentage points)**	**Percentage change between B and M (%)**	**Performance rating**
Latrobe Valley	57.4	61.1	3.7	6.4%	Excellent
Gippsland	56.2	59.1	2.9	5.1%	Excellent
Victoria	52.5	54.2	1.7	3.2%	Good

Source AIHW Cancer Screening Programs Quarterly Data October 2022

Performance rating based on the evaluation rubric as follows:
- Decrease from baseline = very poor
- No change (0–0.9 percentage points) = poor
- Increase of 1 to 1.9 percentage points = fair
- Increase of 2 to 2.9 percentage points = acceptable
- Increase of 3 to 3.9 percentage points = good
- Increase of 4 to 4.9 percentage pints = very good
- Increase of 5 or more percentage points = excellent

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As shown in Table 4.6, BreastScreen Victoria data were analysed to examine screening rates (women aged 50–74) in the specified postcodes of Moe, Morwell and Churchill. AIHW data for Latrobe, Gippsland and Victoria have been included as a comparator (note the differences in time periods between the two data sources for baseline, midway and end data points, which may limit interpretation of results).

The analysis shows that there was a slight decrease in screening rates in Moe (decrease of two percentage points) and Churchill (decrease of 2.7 percentage points) in 2017–2019 compared to baseline (2016–2018). However, a small increase in screening rates was observed in Morwell (growth of 0.7 percentage points) during the same period. Likewise, little to no change in breast screening rates was observed in Latrobe, Gippsland and Victoria in the comparable time period.

The observed growth at the midway point for Morwell was considered *fair* as per the evaluation rubric (see Appendix B), while all decreases were rated as *very poor*.

Finding 5: The analysis indicates breast screening rates for women residing in Moe, Morwell and Churchill were relatively unchanged between 2016-18 and 2017-19.

Data for 2019–2021 were not analysed as it is known that services were ceased due to COVID-19 pandemic measures in this period.

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Table 4.6: Breast screening rates for women aged 50–74 years by sub-region

Location	2016–2018 Baseline (B)[1]	2017–2019[1]			
	Proportion of eligible population (%)	**Proportion of eligible population (%)**	**Change from B (percentage points)**	**Percentage change from B (%)**	**Performance rating**
Moe[1]	57.7	55.7	-2.0	-3.5%	Very Poor
Morwell[1]	54.6	55.3	0.7	1.3%	Fair
Churchill[1]	55.9	53.5	-2.4	-4.3%	Very Poor
Latrobe[2]	58.3	57.4	-0.9	-1.5%	Very Poor
Gippsland[2]	57.0	56.7	-0.3	-0.6%	Very Poor
Victoria[2]	54.1	54.1	0.0	0.0%	Poor
	2016–17 Baseline (B)[2]	2017–2018[2]			

Source: Breast Screen Victoria Data (1), AIHW Cancer Screening Programs Quarterly Data October 2022 (2)
[1] Baseline data captured between 2016–2018, midway data captured between 2017 and 2019, end data captured between 2019 and 2021
[2] Baseline data captured between 2016–2017, midway data captured between 2017 and 2018, end data captured between 2019 and 2020

Performance rating based on the evaluation rubric as follows:
- Decrease from baseline = very poor
- No change (0–0.9 percentage points) = poor
- Increase of 1 to 1.9 percentage points = fair
- Increase of 2 to 2.9 percentage points = acceptable
- Increase of 3 to 3.9 percentage points = good
- Increase of 4 to 4.9 percentage pints = very good
- Increase of 5 or more percentage points = excellent.

Breast screening data for vulnerable population groups including Aboriginal and Torres Strait Islander women and women who speak a language other than English was not available for Latrobe at the midway or end points. Therefore, the potential impact of the Initiative on these cohorts of women could not be assessed.

Cervical cancer screening rates

Historically, cervical cancer screening rates in Latrobe have been below the Gippsland and Victorian screening rates. Further analysis showed that cervical cancer screening rates in Latrobe were lowest among women aged 20–24 years of age. However, this age group was no longer targeted in the national screening program when the new screening test was introduced in December 2017. Therefore, no specific targets were set for cervical cancer screening as part of the Initiative, other than to improve screening rates.

As shown in Table 4.7, cervical screening rates in Latrobe and Gippsland slightly decreased from 2015–16 to 2018–21 by 0.3 and 0.5 percentage points, respectively. During the same period, rates across Victoria increased by 4.9 percentage points. However, a general decrease in cervical screening rates was observed in 2020 due to the COVID-19 pandemic (data not shown), although the full impact of COVID-19 is yet to be ascertained.

Many of the cancer screening activities of the Initiative (e.g. Screen For Me) commenced in 2019, and therefore the impact of these would not be expected to be observed until 2020-21 or beyond. Additional data for subsequent years (2021-22, and 2022-23) are required (when available) to assess the full impact of the Initiative on cervical cancer screening rates for women in Latrobe.

Table 4.7: Cervical cancer screening rates for women

Location	2015–2016	2018–2021	
	Proportion of eligible population (%) (20–69 years)	**Proportion of eligible population (%) (25–74 years)**	
Latrobe	54.4	54.1	-0.3
Gippsland	56.9	56.4	-0.5
Vic	57.0	61.9	4.9

Source: AIHW Cancer Screening Programs Quarterly Data January 2023

Recent AIHW data for cervical smear practice incentive program (PIP) claims from general practice were also analysed. Table 4.8 shows that in 2018–19 Latrobe (0.24%) and Gippsland (0.21%) had comparable cervical smear rates to the national average (0.26%). In all three locations there was a decrease in the rate of cervical smears between 2018–19 and 2019–20, likely due to the COVID-19 pandemic. In 2021–22 Gippsland cervical smear rates remained relatively unchanged, and the national average continued to decrease slightly. In Latrobe however, cervical smear rate rose in 2021–22 to 0.31%, a rise of 0.7 percentage points from 2018–19 baseline. This placed Latrobe cervical smear rates almost three times greater than the national average. These data suggest that the activities of the Initiative (such as the Screen For Me campaign) contributed to the substantial rise in cervical smear rates in general practice.

Table 4.8: Proportion of population with cervical smear PIP claims

Location	2018-19	2019-20	2021-22	
	Percentage of people who had a cervical screen	**Percentage of people who had a cervical screen**	**Percentage of people who had a cervical screen**	**Change (Percentage points) from 2018-19**
Latrobe	0.24%	0.15%	0.31%	0.70
Gippsland	0.21%	0.17%	0.17%	-0.40
National	0.26%	0.17%	0.11%	-0.15

Source: AIHW: Medicare-subsidised GP, allied health and specialist health care across local areas: 2018–19, 2019–20 and 2021–22 (Cervical Smear PIP data). Cervical smear rates presented as proportion of total population.

Finding 6: The analysis indicated that the Initiative contributed to a substantial increase in cervical smear rates in general practice in 2021–22 compared to previous years. However insufficient data were available at the time of evaluation to determine if the increased cervical smear rates reported corresponds to a similar increase in cervical screening rates. Additional data are required to assess the full impact of activities of the Initiative that were delivered between 2019 and 2022.

4.3.3 Opportunistic screening by GPs

A 2019 survey conducted as part of the Initiative sought GP perspectives on approach to and confidence with opportunistic screening. A total of 22% of GPs working in Latrobe participated in the survey. The results indicated that over half of the surveyed GPs indicated they were '*very likely*' to undertake opportunistic screening (n=14, 56%), and half felt confident to do so (n=13, 52%). However, there were some opportunistic screening tests that were more likely to be collected routinely by GPs than others. For example, survey results indicated that:

- over 70% of GPs routinely undertook opportunistic screening for cervical screening (including asymptomatic prompts), blood pressure and cholesterol (range 72% to 88%)
- over 50% of GPs routinely undertook opportunistic screening for type 2 diabetes, cardiovascular disease, kidney disease, drinking, smoking and asymptomatic prompts for breast and bowel screening (range 52% to 68%)
- less than 50% of GPs routinely undertook opportunistic screening for weight (body mass index and waist circumference), physical activity, nutrition, and cervical screening self-collection (range 24% to 44%), and
- only a third (n=9, 36%) of surveyed GPs reported routine use of the Royal Australian College of General Practitioners (RACGPs) 'Red Book' which provides guidelines for preventive activities in general practice.

A second survey of GPs (originally planned for 2021) was not undertaken. Therefore, it was not possible to analyse the broader impact of the activities from the Initiative on GP confidence.

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As a quasi-measure of GP confidence for health screening activities, the proportion of patients with '*unknown*' status for the following health measures were analysed from POLAR data[12]:

- smoking
- alcohol consumption
- blood pressure
- body mass index (BMI), and
- waist circumference.

As per Figure 4.6 and Figure 4.7, the data analysis showed that:

- the unknown status of smoking (less than 15%) was significantly lower than the unknown status for other metrics (range from 40%–95%)
- waist circumference had the highest unknown status ranging from 80% to 95%, followed by BMI ranging from 65% to 70%, and
- there was little difference between unknown status of selected metrics in Latrobe compared to Gippsland (ranging from 0.8 percentage points (smoking at *end*) to 7.7 percentage points (blood pressure at *baseline*).

Finding 7: Smoking status of patients was captured well by GPs in Latrobe and Gippsland, with the smoking status unknown for less than 15% of patients.

Analysis of the change in unknown status over the Initiative period (Figure 4.6 and Figure 4.7) showed that:

- the unknown status of **alcohol consumption** was the only metric to show improvement in the timeframe at both mid-point and endpoint (denoted by *good* and *acceptable* performance ratings in Figure 4.6)
- the unknown status of **smoking** showed minor improvement at mid-point in Latrobe (a decrease of two percentage points, performance rating of *fair* in Figure 4.6) but returned to baseline levels by the end-point. There was essentially no change for the smoking metric in Gippsland, and
- the unknown status for **BMI** showed a small increase from baseline to mid-point and end-point for Latrobe (denoted by *very poor* performance rating in Figure 4.6). However, in Gippsland unknown status for BMI showed a small decrease at mid-point (denoted by *fair* performance rating in Figure 4.6), which returned to baseline by the end-point.
- the unknown status for **blood pressure** and **waist circumference** both showed small increases from baseline to mid-point and endpoint for Latrobe and Gippsland (denoted by *very poor* performance rating in Figure 4.6).

Finding 8: Recording of alcohol consumption in general practice patient management systems was the only opportunistic screening metric to demonstrate a positive trend (decrease) in the proportion of 'unknown' status during the Initiative.

With the exception of alcohol consumption all metrics showed a slight increase in unknown status at the end-point in 2021. This is mostly likely a result of the COVID-19 pandemic and shifts in GP and patient priorities during this time, as well as reflecting a shift to virtual consults (phone or videoconference) which limit physical measures such as blood pressure and, to a lesser extent, waist circumference and BMI.

Finding 9: COVID-19 is likely to have impacted opportunistic screening by GPs for most metrics, possibly except for alcohol consumption.

[12] POLAR data are extracted from GP practice client management systems and dashboard indicators were created as part of the Initiative by Outcome Health. Not all practices use POLAR, and overall statistics are susceptible to practices being added or removed from the dataset. Therefore, baseline has been considered as December 2018 across all indicators, reflecting fewer changes to practices using POLAR and hence less 'artificial' fluctuation in measures.

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Figure 4.6: Unknown status for opportunistic screening measures at baseline (Dec 2018), midway (Jun 2020) and end (Dec 2021)

Screening measure	Region	Baseline (B) (Dec 2018)	Midway (June 2020)			End (Dec 2021)		
		Proportion of population (%)	Proportion of population (%)	Change from B (percentage points)	Performance rating	Proportion of population (%)	Change from B (percentage points)	Performance rating
Smoking	Latrobe	14.5	12.5	-2.0	Fair	14.5	0.0	Poor
	Gippsland	13.4	13.0	-0.4	Poor	13.7	0.3	Very Poor
Alcohol consumption	Latrobe	59.0	47.6	-11.4	Good	47.2	-11.8	Good
	Gippsland	53.0	44.1	-8.9	Acceptable	42.8	-10.2	Good
Blood pressure	Latrobe	44.4	47.7	3.3	Very Poor	51.2	6.8	Very Poor
	Gippsland	43.0	46.0	3.0	Very Poor	47.9	4.9	Very Poor
BMI	Latrobe	65.1	65.7	0.6	Very Poor	67.7	2.6	Very Poor
	Gippsland	67.6	66.5	-1.1	Fair	67.3	-0.3	Poor
Waist circumference	Latrobe	86.6	88.1	1.5	Very Poor	93.2	6.6	Very Poor
	Gippsland	92.1	92.8	0.7	Very Poor	95.7	3.6	Very Poor

Source: POLAR data provided by Gippsland PHN
Performance ratings as per evaluation rubric provided in Appendix B.

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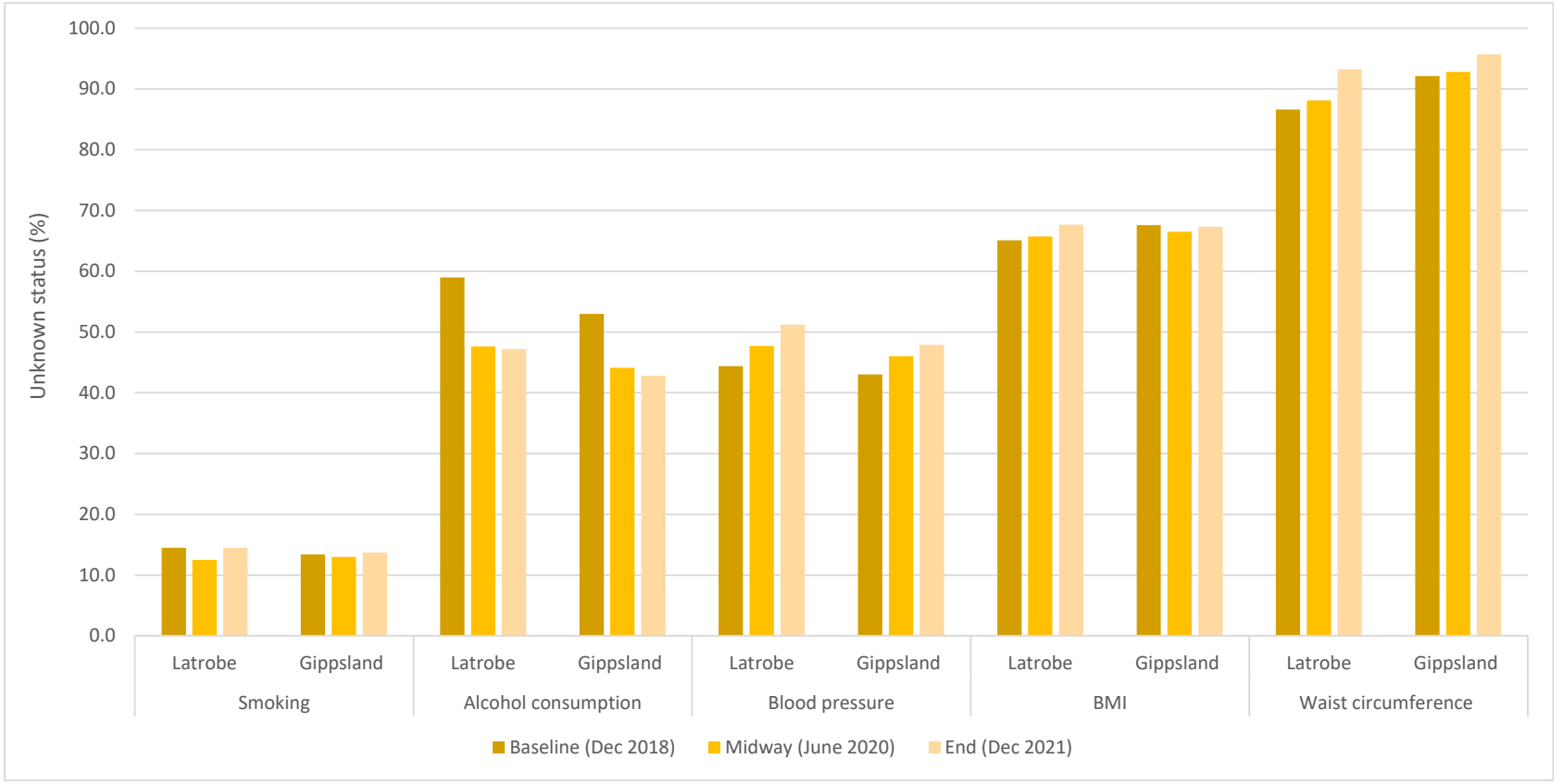
Figure 4.7: Unknown status for opportunistic screening measures at baseline (Dec 2018), midway (Jun 2020) and end (Dec 2021)



Source: POLAR data provided by Gippsland PHN

4.3.4 Referrals to support programs

Through the training and education programs offered, the Initiative aimed to increase GP and other health professional referrals to support programs such as Quitline (for smoking cessation) and Life! (for prevention of diabetes through lifestyle management).

This section examines referral data from Quit Victoria and Life! during the Initiative period.

Quitline

As shown in Figure 4.8, referrals from health professionals in Latrobe (and Baw Baw) to Quitline increased from baseline (2016) in all years of the Initiative with the exception of 2019. A similar trend was observed for the Gippsland region.

An *excellent* increase in referrals from health professionals was observed in Latrobe (including Baw Baw) in 2018 (72.1% increase from baseline), and also across Gippsland (91.4% increase from baseline). This corresponded to the *Pitch to Quit* campaign (January to March 2018) and the *Smoke-free Innovation Workshops* held in October 2018; and built on the following smoking cessation related activities of the Initiative from 2017: Quit education sessions for GPs and nurses (May–June 2017) and Quit Victoria community education stalls (June 2017).

The sudden drop in health professional referrals to Quitline observed in 2019 is an anomaly and pre-dates COVID-19 pandemic measures. However, during this time the Initiative had very little focus on smoking cessation activities (cancer screening was the predominant focus in this year), which may in part explain the decline. Referrals improved in 2020 (44.3% increase for Latrobe/Baw Baw (*very good*) and 69.1% increase for Gippsland (*excellent*)), corresponding with the Smoke-free *Gippsland Three Step Brief Intervention Model* (GP Training/Incentive) (November 2019 to April 2020) and the *Pharmacy Smoking Cessation Program* (October 2020 to May 2021).

There was another decline in referrals to Quitline by health professionals in 2021 with only a *fair* increase compared to baseline for both Latrobe / Baw Baw (11.5% increase) and Gippsland (7.4% increase). During this timeframe the Initiative undertook the continuation of the *Pharmacy Smoking Cessation Program*, the second *Pitch to Quit* campaign (March to May 2021) and the *Latrobe Smoking Support Service* (June 2021 to March 2022). This may reflect impacts of COVID-19 pandemic measures occurring at this time.

Improvements observed for Quitline referrals by health professionals from 2016 to 2020 in Latrobe were mirrored across the Gippsland region. As education and training programs were offered throughout Gippsland (and not just in Latrobe), these results may still be in part attributable to the efforts of the Initiative.

Figure 4.8 also shows the proportion of Quitline callers that were using Nicotine Replacement Therapy (NRT) at the time of the call. In both Latrobe / Baw Baw and Gippsland there was an increase in use of NRT by Quitline callers across all years, with growth exceeding 600% increase by 2021 for both Latrobe / Baw Baw and Gippsland[13].

Finding 10: Increased referrals from health professionals to Quitline corresponded to times when health professional education / training on smoking cessation was undertaken but waned during periods with no corresponding education / training. The proportion of Quitline callers using NRT increased significantly from baseline to 2021. The trends were observed in Latrobe, Baw Baw, and more broadly across Gippsland, reflecting the inclusion of the Gippsland region in training / education initiatives.

[13] The low starting point of less than 20 people for both Latrobe / Baw Baw and Gippsland must be acknowledged when interpreting the percentage growth over time.

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Figure 4.8: Quitline referrals and callers using NRT

Indicator	Region	Baseline (B) 2016	2017			2018			2019			2020			2021		
		n	n	% change from B	Performance rating	n	% change from B	Performance rating	n	% change from B	Performance rating	n	% change from B	Performance rating	n	% change from B	Performance rating
Quitline referrals by health professionals	Latrobe and Baw Baw	61	73	19.7	Acceptable	105	72.1	Excellent	55	-9.8	Very poor	88	44.3	Very good	68	11.5	Fair
	Gippsland	81	117	44.4	Very good	155	91.4	Excellent	80	-1.2	Very poor	137	69.1	Excellent	87	7.4	Fair
Quitline callers using NRT	Latrobe and Baw Baw	13	16	23.1	Acceptable	39	200.0	Excellent	39	200.0	Excellent	29	123.1	Excellent	98	653.8	Excellent
	Gippsland	19	27	42.1	Very Good	67	252.6	Excellent	73	284.2	Excellent	53	178.9	Excellent	164	763.2	Excellent

Source: Quit line Victoria

Performance rating based on the evaluation rubric as follows:
- Decrease from baseline = very poor
- No change = poor
- Increase of 1% to 12.5% = fair
- Increase of 13% to 24.5% = acceptable
- Increase of 25% to 37.5% = good
- Increase of 38% to 49.5% = very good
- Increase of 50% or more = excellent

Life!

Figure 4.9 shows the change over time in referrals to the Life! program for residents of Latrobe. There was a significant increase in all referrals between baseline (estimated based on 2016–17 financial year timeframe) compared to the 2017 and 2018 calendar years (171% and 129% increase from baseline, respectively). In 2017 the increase was across referrals from any source (self, GP or other health professionals/facilitators/providers). However, in 2018 the number of GP referrals fell back to baseline levels, and self-referrals halved compared to 2017. Only 'other health professionals/facilitators/providers' continued to show an increase in referrals. In 2019, the total number of referrals decreased below baseline levels (decrease of 9%). There was a reduction in referrals from all sources, but only referrals from GPs dropped below baseline levels (decrease of 72% from baseline). Baseline data for Life! referrals from Gippsland were not available for comparison.

The only Initiative related activity occurring in Latrobe between 2017 and 2018 was the *Health Check Risk Assessment Tool for Chronic Disease Pilot* (August 2017 to February 2018) and the ongoing work of the *Health Pathways* project (although there were no pre-diabetes specific pathways promoted during this timeframe). Although the evaluation of the Health Check Pilot had unfavourable findings about the tool and the process, it is possible that the act of running the pilot contributed to the increase in Life! referrals observed.

Finding 11: Initial increases in referrals to Life! from GPs were not maintained in the long-term suggesting that ongoing activities and prompts are required to create lasting behaviour change.

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Figure 4.9: Referrals to Life! and percentage change over time for Latrobe

Referrer	Baseline (B) 2016-17*	2017			2018			2019		
	n	n	% change from baseline	Performance rating	n	% change from baseline	Performance rating	n	% change from baseline	Performance rating
Self	12	45	275	Excellent	33	175	Excellent	18	50	Excellent
GP	46	90	96	Excellent	46	0	Poor	13	-72	Very poor
Other	29	101	248	Excellent	120	314	Excellent	48	66	Excellent
Total	87	236	171	Excellent	199	129	Excellent	79	-9	Very poor

Source: Life! referral data
* 2016-2017 data estimated as 4/5th of July 2016 to September 2017 data

Performance rating based on the evaluation rubric as follows:
- Decrease from baseline = very poor
- No change = poor
- Increase of 1% to 12.5% = fair
- Increase of 13% to 24.5% = acceptable
- Increase of 25% to 37.5% = good
- Increase of 38% to 49.5% = very good
- Increase of 50% or more = excellent.

Figure 4.10: Life! referral data by referrer for Latrobe and Gippsland[14]

Location	Referrer	2016-17*		2017		2018		2019	
		n	% of total	n	% of total	n	% of total	n	% of total
Latrobe	Self	12	14	45	19	33	17	18	23
	GP	46	53	90	38	46	23	13	16
	Other	29	33	101	43	120	60	48	61
	Total	**87**	**100**	**236**	**100**	**199**	**100**	**79**	**100**
Gippsland	Self		-	403	37	69	10	138	36
	GP			359	33	241	34	98	26
	Other			335	31	391	56	143	38
	Total			**1,097**	**100**	**701**	**100**	**379**	**100**

Source: Life! referral data. *2016-2017 data estimated as 4/5 of 1 July 2016 to 30 September 2017 data.

[14] Baseline is estimated on a financial year, while the remaining time points are calendar year estimates.

As shown in Figure 4.10, examination of Life! referral data also indicated that in Latrobe the proportion of referrals by other health professionals/facilitators/providers increased at a greater rate than other referral types, increasing from 33% at baseline to 60% in 2018 and 61% in 2019. This may suggest that targeting other health professionals to refer to the Life! program has a greater chance of success than just targeting GPs.

Finding 12: Targeting other health professionals/facilitators/providers for referrals to the Life! program may be more sustainable than targeting only GPs.

4.4 CONCLUSION

Community facing impacts

Analysis of population health data up to 2020 showed there had been little change to overall smoking rates or cancer screening rates in Latrobe compared to baseline figures in 2016-17. However, the proportion of Quitline callers using NRT increased significantly from baseline to 2021. This demonstrates an increased awareness in the community about the combined benefits of NRT and counselling services during this time.

In addition, many of the Initiative activities / programs commenced from 2019 onwards and are unlikely to have demonstrated any impact by 2020. Additional data for 2021 onwards is needed to fully understand potential impacts of the Initiative on smoking and cancer screening rates.

The effects of the COVID-19 pandemic on health-related behaviours is difficult to estimate. Studies have highlighted increased anxiety and distress caused by the pandemic. Smokers were more likely to smoke more (rather than less) during the pandemic[15][16]. The increase in smoking rates observed across Gippsland between 2019 and 2020 could be attributed to effects of the COVID-19 pandemic.

Similarly, people had reduced access to cancer screening during the pandemic (especially during periods of lockdown), such as closures to breast screening services resulting in a decrease in breast screening rates in 2020.[17] .

Despite this, many cancer screening rates in Latrobe remained above Victorian rates in 2020. Exceptions to this were bowel screening for men aged 50–59 years and cervical screening, which were both slightly below the Victorian average. Conversely, breast screening for women aged 70–74 in Latrobe increased above the state average in 2018-19, demonstrating high awareness levels among Latrobe women.

Recommendation 1: Collect and analyse additional smoking and cancer screening data for 2021 onwards (and for specified target groups such as bowel screening rates for men in the postcodes of Moe and Morwell), to determine the full impacts of the Initiative.

Health system facing impacts

Analysis of available information demonstrated that there had been little change to the recording of patient health metrics by GPs during the Initiative. Alcohol consumption was the only metric to demonstrate a positive trend (decrease in the proportion of 'unknown' status) during the Initiative. However, changes in priorities during the pandemic for GPs and patients may have limited the focus on opportunistic screening and reduced face-to-face consultations will have limited collection of metrics such as blood pressure. Further information now that pandemic measures have ceased is required to understand the full impact of the Initiative on GP behaviour regarding opportunistic screening.

Recommendation 2: Collect and analyse primary care data for 2022 onwards, and re-survey GPs about opportunistic screening behaviours.

However, education activities relating to referral processes for Quitline and the Life! program correlated with increased referrals to these services but waned during

[15] Factors associated with psychological distress, fear and coping strategies during the COVID-19 pandemic in Australia. Rahman et al. 2020, *Globalization and Health* Vol. 16, Article number: 95.
[16] Abstract #: 1343. A systematic review and meta-analysis of tobacco smoking behaviour changes during the COVID-19 pandemic. Vaneckova et al. 2021. *International Journal of Epidemiology,* Vol. 50, Supplement 1
[17] AIHW report. Cancer screening and COVID-19 in Australia

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periods with no corresponding education / training. This demonstrates that ongoing need for education or prompts to maintain behaviour change among health professionals (at least in the short to medium term). In addition, targeting education campaigns regarding referral programs to non-GP health professionals / service providers may have more sustainable effects, especially in consideration of the high level of GP turnover in Gippsland.

Recommendation 3:	Consider and plan for recurrent education / prompts in future activities targeting behaviour change among health professionals.

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5.1 SUMMARY

The Initiative included a good mix of the types of activities undertaken across all three themes, which engaged good numbers of the community of Latrobe. Social media was a wide-reaching medium especially when cross promoted by relevant stakeholders and therefore was an effective way to promote campaign messaging. Further information on behaviour change within the community is required to assess the reach and impact of the social marketing campaigns.

Despite numerous projects within the cancer screening theme that focused on Aboriginal and Torres Strait Islander people, more work could be done to target vulnerable population groups including culturally and linguistically diverse people and LGBTIQ+ people, especially for smoking cessation and opportunistic screening themes.

Behaviour change for individuals and system redesign / process change within healthcare practices requires time and ongoing supports until the desired changes become routine and embedded.

5.2 EVALUATION QUESTIONS

The meta-evaluation sought to assess the extent to which the Initiative achieved its short to medium-term outcomes including:

> *To what extent the community have improved understanding of smoking risks, the benefits of cancer screening and the importance of health lifestyles?*
>
> *To what extent health professionals have improved skills to support clients to quit smoking, actively promote cancer screening and routinely monitor chronic disease risk factors?*

Detailed evaluation questions were:

Community facing

- What strategies were most effective in engaging the community in program design and implementation?
- What were the barriers and enablers of program implementation?
- Did the initiatives increase perceived value or minimise perceived barriers of quitting smoking, cancer screening programs and other health screening initiatives?
- What was the reach of the initiatives, and were population sub-groups engaged?
- To what extent did the initiatives change the attitudes, beliefs and/or behaviours of community members?
- What was the reach/recall of the social marketing initiatives?

Health professionals

- To what extent did formal training programs increase health professionals' awareness of smoking cessation, cancer screening and opportunistic screening?
- To what extent were health professionals able to implement the smoking cessation training received?
- What quality improvement system re-design initiatives enabled GP practices to make practice-wide changes that support smoking cessation, cancer screening and opportunistic screening, e.g. improved data collection and patient management systems, process/system redesign?

5.3 ANALYSIS AND FINDINGS

5.3.1 Community engagement and reach of community facing initiatives

Assessment of the reach of activities undertaken as part of the Initiative was undertaken through consideration of media campaigns implemented, social media metrics (e.g. Facebook followers/likes, video views) and individual program/project evaluation reports.

Program reach and participation

Figure 5.1 shows the number of activities implemented under the Initiative (by focus area) and the number of participants engaged in each activity. This shows that there was three times the number of cancer screening related activities with a community focus (nine activities) compared to smoking cessation (three activities) and opportunistic screening / health checks (three activities). Activities targeted people across the continuum of behaviour change, from awareness raising / information provision, to direct behaviour change activities. There was also a range of consumer engagement (reach) for each activity, ranging from less than 10 to over 400 participants.

As shown in Figure 5.1, awareness raising activities (yellow rows) ranged from 90 people (community Quit stalls) to 277 people (Latrobe Smoking Support Service).

There was an initial plan to assess the broad reach of social marketing activities through an assessment of community recall via a computer assisted telephone interview (CATI) process., The CATI survey did not proceed as planned and therefore broader reach of initiatives within the community was not assessed. Some initiatives, e.g. Pitch to Quit and Screen For Me had a broader reach via social media, which is discussed in the following section (*reach of social media*).

Direct support activities (grey rows) had a range of engagement also, from 10 participants (Churchill Neighbourhood Centre Bust Trip) to over 400 (use of the online Integrated Risk Assessment Tool for Chronic Disease). Activities with good reach included:

- the Latrobe Smoking Support Service: 117 enrolments.
- BreastScreen Victoria's (BSV) Lapsed Breast Cancer Screening Campaign: 197 appointments made, and 169 screens undertaken, and
- Student-led pop-up health check: 188 health checks completed.

Figure 5.1: Community participation in Initiative activities

Initiatives	Target Audience	No. of attendees
Smoking cessation		
Community Quit Stalls	General public, Latrobe	• 90 people: 30 per day over 3 days • 23 Quitline referrals
Pitch to Quit	Youth, Latrobe	• Round 1: 26 submissions • Round 2: 6 submissions • See *Reach of social media*
Pharmacy campaign	Customers within pharmacies in Latrobe	• 3 pharmacies
Latrobe Smoking Support Service	Smokers in the Latrobe region	• 117 enrolments • 71 returning clients
Cancer screening		
BSV Pharmacy Campaign	Customers within pharmacies in Latrobe	• 7 pharmacies • 277 conversations initiated
BSV – International Women's Group Latrobe presentation	Culturally and linguistically diverse women	20 women
BSV – Gippsland Strategy – Hazelwood Project Health promotion, capacity building, media and marketing activities to promote the mobile screening service	• Women in Morwell, Moe and Churchill • Aboriginal women in Morwell (Ramahyuck)	• 191 women screened • 18 first time screeners • 65 overdue screeners • 16 Aboriginal women

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Initiatives	Target Audience	No. of attendees
Screen For Me – community led cancer screening grants	• Men in Latrobe (Men's Shed) • Culturally and linguistically diverse people (Filipino community)	• Men's Shed: 25 participants • Filipino Community: 22 participants
Screen for me – roving ambassadors	General public, Latrobe	n/a
Screen for me – pop-up information in local business (including polaroids)	General public, Latrobe	n/a
Screen for me – Aboriginal co-design videos	Aboriginal men and women	See *Reach of social media*
Ramahyuck Pamper Day – importance of breast and cervical cancer screening, and health checks	Aboriginal Women	25 women
Gathering Place Bowel Comedy	General public, adults in Latrobe, Aboriginal and Torres Strait Islander people	20 people
BSV– Breast Cancer Screening Shawl Project	Aboriginal Women	13 Aboriginal women
Churchill Neighbourhood Centre Bust Trip	Women in Churchill	10 participants
BSV– Lapsed Breast Cancer Screening Campaign	Lapsed screeners: 50–74 year old women who have not had a breast cancer screen for over 27 months	• 197 appointments made by lapsed screeners • 169 appointments undertaken at the time of the project evaluation
BSV– BreastScreen Letters – GP endorsement	Lapsed screeners: 50–74 year old women who have not had a breast cancer screen for over 27 months	• 112 co-branded letters sent • 20 appointments booked (17.9% response rate) • 530 standard reminder letters sent • 68 appointments booked (12.8% response rate)
Risk assessment and opportunistic screening		
Health Check: Integrated Risk Assessment Tool for Chronic Disease	General public, adults in Latrobe	Phase 1 – Pilot: • health checks sent to 102 people • 38 people provided feedback Phase 2 – broader roll out: • paper health check not widely used • 410 online sessions via the Better Health Channel
Risk Assessment in Community Settings (GP outreach health checks)	General public, adults in Latrobe	56 participants screened
Student-led Pop-Up Health Check	General public, adults in Latrobe	188 participants

Source: Initiative program reports and evaluation reports, Gippsland PHN mid-term reports. Yellow = awareness raising activities, grey =direct support activities.

Finding 13: There was a good mix of the types of activities undertaken to engage community members including online, social media, written reminders and in person clinics. The Initiative activities were able to

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reach and engage large numbers of the community of Latrobe (and surrounding areas), albeit this was still only a small proportion of the total population of Latrobe (over 77,000 people as at the 2021 census[18]).

Media campaigns

A number of media campaigns were launched through the Initiative period to promote specific activities or programs, as indicated in Figure 5.2. Media campaigns included a mix of print, television, radio, social media and Gippsland PHN web-stories.

Twenty-eight media campaigns were launched from 2018 to 2021. Two thirds of these focused on cancer screening (64%, n=18), one third focused on smoking cessation (32%, n=9) and one campaign focused on risk assessments and opportunistic screening.

[18] https://abs.gov.au/census/find-census-data/quickstats/2021/LGA23810

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Figure 5.2: Media campaigns and mode for Initiative activities

Timeframe	Project	Topic	TV	Print	Radio	Social Media	GPHN web story	Other
October 2018	Smoking cessation	Media release – Smokefree Latrobe Innovation workshop		✓	✓			
November 2018	Breast Screening	Churchill Neighbourhood Centre – Bust trip		✓				
April 2019	Breast Screening	Media Release – Latrobe BreastScreen Pharmacy Campaign		✓		✓		
May 2019	Cancer Screening	Screen For Me Campaign Launch: WIN News, Nine News Gippsland, Latrobe Express	✓	✓	✓	✓		
May 2019	Smoking Cessation	Smokefree Gippsland Launch: 9 News Gippsland	✓	✓	✓	✓		
July 2019	Cancer Screening	Local businesses support Screen For Me					✓	
August 2019	Cervical Screening	Cervical Screening - response to wait times		✓		✓		
September 2019	Cancer Screening	Qualitative Cancer Screening Research	✓			✓	✓	
October 2019	Breast Screening	Screening shawl project	✓			✓		
October 2019	Cancer Screening	Collaborative approach to increase screening rates				✓	✓	
November 2019	Breast Screening	Conference presentation – BreastScreen Pharmacy Project				✓	✓	✓
November 2019	Cancer Screening	Conference presentation – Qualitative Cancer Screening Research				✓	✓	✓
November 2019	Smoking Cessation	Local finalist in Victoria's premier health awards				✓	✓	✓
April 2020	Smoking Cessation	Pitch to Quit competition launch – TRFM interview			✓	✓	✓	
May 2020	Smoking Cessation	Pitch to Quit competition launch – Latrobe Express		✓				
May 2020	Cancer Screening	Podcast 001 – Latrobe Cancer Screening Collaborative				✓	✓	
May 2020	Cancer Screening	Podcast 002 – Latrobe Cancer Screening Collaborative				✓	✓	
May 2020	Cancer Screening	Podcast 003 and 004 – Latrobe Cancer Screening Collaborative				✓	✓	
June 2020	Cancer Screening	Latrobe Cancer Screening Collaborative – Latrobe Express		✓			✓	
June 2020	Smoking Cessation	Pitch to Quit		✓				
September 2020	Smoking Cessation	Pitch to Quit Competition Outcome		✓	✓			
September 2020	Cancer Screening	Social Network Analysis – Participant Recruitment – WIN Network	✓					
November 2020	Cancer Screening	Screen For Me – COVID and Cervical screening	✓	✓	✓			
May 2021	Smoking Cessation	Pitch to Quit Competition Outcome			✓			
May 2021	Smoking Cessation	Pitch to Quit Competition Launch and Running	✓	✓		✓	✓	
May 2021	Cancer Screening	Screen For Me Campaign relaunch	✓	✓	✓	✓		
August 2021	Risk assessment and opportunistic screening	Pop Up Health Checks			✓	✓		
Total	**28 campaigns**		**8 (29%)**	**13 (46%)**	**9 (32%)**	**17 (61%)**	**12 (43%)**	**3(11%)**

Source: Gippsland PHN mid-term reports.

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Finding 14: Multiple media campaigns were used through the Initiative to promote activities. These focused largely on cancer screening, followed by smoking cessation. Only one campaign focused on risk assessment / opportunistic screening, which occurred late in the Initiative timeframe (2021).

As shown in Figure 5.2, social media was the most used media type being used in 61% of media campaigns. This likely reflects the relatively inexpensive nature and broad reach of this media type. However, it is known that social media is not preferred by ageing population cohorts. A high level of print media was also used (46%), to enable engagement from people that do not use social media. Traditionally, television and radio are also used to engage this cohort, but these are relatively expensive forms of media compared to print and social media. Both television and radio were used within media campaigns, but to a lesser extent (29% and 32%, respectively). Gippsland PHN web-stories were also used as an inexpensive marketing tool for 43% of media campaigns.

Finding 15: Social media was the most used type of media for campaigns under the Initiative.

Reach of social media

Gippsland PHNs Facebook page has 2,441 followers. This provided a useful platform for information dissemination for Initiative activities. Two programs of the Initiative had a large social media presence, as follows:

- Smoking cessation: Pitch to Quit competition, and
- Cancer screening: Screen For Me.

These two programs are considered in more detail as case studies.

Case study #1: Pitch to Quit

Pitch to Quit is a competition for people to make short videos to promote smoking cessation. The competition targets young people (adolescents and young adults) but is not limited to this age cohort. The inaugural competition ran in 2018 and was repeated in 2021. The video and related marketing material of the competition winner is used for social marketing materials in the Latrobe Valley.

At the time of this evaluation (December 2022) the Pitch to Quit Facebook page had 285 followers and 267 page likes, representing a small reach. The Facebook page included links to the winning videos from 2018 as well as other submissions. In addition, submitted videos can be found on YouTube, and the 2018 winning video was promoted through Quit Victoria's website.

As shown in Figure 5.3, social media enabled the videos to be wide-reaching (with the 2018 winner – It's Time – achieving over 64,000 views on YouTube), with reach of 2018 videos being exponentially higher than 2021 videos. This may reflect diminishing impact over time, or simply the need for more time for people to engage with recent media content.

Figure 5.3: Pitch to Quit video views

Video	Views
2018 winner: Its Time	Multiple Facebook posts: over 9,200 views You Tube as advertised through Quit Victoria: 64,000 views
Other 2018 entries	
Overcome the hurdles	Facebook posts: 7,600 views
Not alone	Facebook posts: 7,500 views
Save a life	Facebook posts: 4,600 views
A better path	Facebook posts: 2,500 views
2021 winner: Quit smoking. Together.	Facebook posts: 140 views You Tube: 75 views

Source: Pitch to Quit Facebook page: https://www.facebook.com/PitchToQuit/videos
You Tube (2021 winner): https://www.youtube.com/watch?v=T-asoifJiCQ
Quit Victoria: https://www.quit.org.au/news/latrobe-valleys-pitch-quit-winner-star-digital-anti-smoking-campaign-launching-next-week/

Case study #2: Screen For Me (social media focus)

Screen For Me was designed as a community-based campaign that aimed to increase participation in the National Cancer Screening Programs for breast, bowel and cervical cancer in Latrobe. It encouraged members of the community to be 'community messengers' to influence a loved one to participate in cancer screening

– by asking loved ones to 'Screen For Me'. In addition, it encouraged community conversations about the importance of cancer screening and early detection.

The Screen For Me campaign launched in May 2019 and was relaunched in May 2021 after a decline in activities due to COVID-19 pandemic measures. As well as the face-to-face activities of the campaign, it also had a social media presence through Facebook and Instagram.

At the time of this evaluation (December 2022) the Screen For Me Facebook page had 944 followers and 908 likes, representing a moderate reach. More detailed social media analytics were captured for the first launch of Screen For Me from 10 May 2019 to 31 July 2019. This data showed that the Facebook page had:

- 667 page likes and 82 posts
- an average organic reach of posts of 585 people, with a highest organic reach of 3,108
- an average paid reach of post of 4,537 people, with a highest paid reach of 8,127, and
- a cumulative lifetime 'likes' on posts of 3,008, with lifetime 'comments' on posts totalling 229 and 'shares' totalling 295.

During the same two-and-a-half-month period the Screen For Me Instagram page had a total of 69 posts and 348 followers.

The social media analytics demonstrate that even with just a moderate number of followers, Facebook posts can be wide-reaching, which can be enhanced with 'paid' marketing of posts.

Screen For Me – personal videos

As part of the development of Screen For Me materials and resources for Aboriginal and Torres Strait Islander people, a series of personal stories were documented as videos and shared via Facebook. As shown in Figure 5.4, there was good collective reach of the videos (over 32,000), and over 1,000 reactions, comments or shares of the videos collectively.

Figure 5.4: Screen For Me social media videos – Aboriginal and Torres Strait Islander people

Video	Date posted	Reach	Post engagement	Total reactions, comments and shares
Nic's Story	18/7/19	7,304	1,034	316
Nic's Story	02/12/19	15,422	2,088	439
Laurie's Story	29/7/19	356	53	18
Carolyn's Story	28/7/19	6,529	320	72
Cliff's Story	22/7/19	2,835	526	147
Ashleigh's Story	19/7/19	404	72	17
Total	-	32,850	4,093	1,009

Source: LHIZ Initiative mid-term report, December 2019, provided by Gippsland PHN

Screen For Me – Roving ambassadors

The Roller Derby ambassadors for Screen For Me also made a short promotional video accessible via the Screen For Me Facebook page (available here).

The reach of this video was almost 3,000 people with over 50 reactions, comments and shares.

Finding 16: Social media can be wide-reaching within the community and can therefore be an effective way to promote campaign messaging. However, it is recognised that not all community members engage with this media type.

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Engaging vulnerable population groups

A range of activities under the cancer screening and opportunistic screening themes targeted Aboriginal and Torres Strait Islander people and culturally and linguistically diverse populations. One cancer screening activity also focused on the LGBTIQ+ community. There were no activities under the smoking cessation theme that specifically targeted vulnerable population groups.

Activities that focused on vulnerable population groups were:

- **Screen For Me**
  - Tailored promotional materials were developed specifically for Aboriginal and Torres Strait Islander people (see Figure 5.5)
  - A series of personal story videos were made with Aboriginal and Torres Strait Islander people and available on the Screen For Me Facebook page
  - Aboriginal and Torres Strait Islander Women's Business Luncheon
  - Community engagement activities with the Filipino community focused on bowel screening (community-led grant)
  - Ramahyuck NAIDOC Week Community Family Days, and
  - Promotional materials (for cervical screening in particular) were reviewed and tailored for inclusivity of LGBTIQ+ communities.
- **BreastScreen Victoria**
  - Gippsland Strategy – Hazelwood Project included specific promotional activities for Aboriginal and Torres Strait Islander and culturally and linguistically diverse women to promote screening when the mobile screening service was in town; 19 Aboriginal and Torres Strait Islander women and 32 women who were born overseas undertook screening at this time
  - The Aboriginal Breast Screening Shawl Project was undertaken in partnership with Ramahyuck District Aboriginal Cooperation, the Victorian Aboriginal Community Controlled Health Organisation, Latrobe Regional Hospital and Gippsland PHN; cultural breast screening shawls were developing using designs from a local Aboriginal woman; 13 Aboriginal and Torres Strait Islander women participated in a group breast screen booking, and
  - International Women's Group Latrobe which included a presentation regarding cancer screening to 20 culturally and linguistically diverse women.
- **Ramahyuck Pamper Day** was an opportunity for women to gather together to share a meal while discuss important health messages including breast cancer screening, recent changes to cervical cancer screening, and the importance of regular health checks; 25 women attended.
- **Gathering Place Bowel Comedy**, targeting Aboriginal and Torres Strait Islander men and women; approximately 20 people attended.
- **GP outreach health checks**, one clinic specially targeted a culturally and linguistically diverse community groups, where 19 people attended for a health check.

Finding 17: The cancer screening theme included activities that focused on Aboriginal and Torres Strait Islander people and, to a lesser extent, culturally and linguistically diverse people and the LGBTIQ+ community.

Very few other activities / programs under the Initiative reported on the participation rates of Aboriginal and Torres Strait Islander and/or culturally and linguistically diverse people. Where this was reported, the participation rates were low, as follows:

- although not specifically reported on, the student-led GP pop-up clinics included a case study of an Aboriginal woman's experience, indicating that at least one Aboriginal and Torres Strait Islander person participated in the health check
- Latrobe Smoking Support Service reported participation from four Aboriginal and Torres Strait Islander people (3%), and
- co-branded reminder letters from BSV and local GP clinics did not result in any Aboriginal and Torres Strait Islander women attending for screening.

Finding 18: Activities / projects that specifically targeted vulnerable people were successful, while non-targeted programs showed very low participation rates from vulnerable population groups.

Figure 5.5: Example of Screen For Me promotional material tailored for Aboriginal and Torres Strait Islander people

5.3.2 Behaviour and attitudes of community members

The evaluation methodology had planned to include a computer assisted telephone interview (CATI) of Latrobe residents to assess the impact of the initiative activities on their attitudes and behaviours towards smoking, cancer screening and opportunistic screening. The CATI did not proceed as planned, limiting broader assessment of impact on community attitudes and behaviours.

Finding 19: There was no information to assess the effect of Initiative activities on consumer attitude and behaviour.

5.3.3 Training program for health professionals

Health system facing activities of the Initiative focused on:

- education and training for health professionals
- updates to HealthPathways to ensure currency and relevancy
- process redesign to support general practice identify under-screened or at-risk individuals
- system re-deign e.g. trialling new models of care / clinics to increase community engagement.

Most of the activity (six projects) focused on general practice with few activities specifically targeting allied health professionals or dentists[19]. Two programs specifically targeted pharmacists: BreastScreen Victoria Pharmacy Campaign, and the Quit Pharmacy Campaign. One program specifically targeted nurses: Cervical Screening Accreditation Program.

At the time of Initiative, there were 86 General Practices in Gippsland, 24 of which are in Latrobe. Figure 5.6 shows education programs targeting health professionals under the Initiative. Several training programs were undertaken to support general practice improve data capture, quality improvement activities (including practice incentive payments (PIP)), and education on MBS item use regarding chronic disease. The Smoking Cessation Education had good participation with 12 general practices engaged in the training (50% of practices in Latrobe). However, only five practices completed the associated quality improvement activities. Uptake of the remaining activities was low among general practice (three to five practices engaged) and the potential process changes resulting were not measured (with the exception of the Latrobe Cancer Screening Collaborative – see Case study #3 on subsequent pages). These results must be interpreted in light of the COVID-19 pandemic impact. General practices reported fatigue and reduced capacity to undertake education unrelated to the pandemic.

[19] Some training programs originally intended to include a broader range of health professionals. However, these did not occur.

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Figure 5.6: Health professional training programs under the Initiative

Training Program	Target Audience	No. of attendees
Smoking cessation		
Smoking Cessation Education	• Health professionals (10 education events): – 4 for GPs – 3 for dental health – 1 for nurses – 1 for pharmacists – 1 for allied health (general) • Target areas: Moe, Traralgon, Morwell (and Warragul in Baw Baw)	• Total of 108 participants: – 24 GPs – 35 dental health professionals – 27 nurses – 11 pharmacists – 6 allied health – 5 others (care coordinators, project officers, practice managers) • 12 general practices participated • GPs from 5 clinics completed the quality improvement activities
Smokefree Gippsland	General practices	• 4 general practices enrolled • 1 general practice completed the brief advice training module • 0 general practice completed the PDSA activity
Quit pharmacy campaign: Talk to your Pharmacist campaign (use of NRTs & referral to Quitline)	Pharmacies in Latrobe	• 3 pharmacies engaged and displayed Quit materials • 0 pharmacies completed training or final survey
Cancer screening		
Screen For Me Collateral within Clinical Settings and Engaging the General Practice	General practices	3 general practices
Latrobe Cancer Screening Collaborative	General practices	4 general practices
BreastScreen Victoria Pharmacy Campaign	Pharmacies in Latrobe	7 pharmacies: • 10 pharmacists • 30 additional staff
Cervical Screening Accreditation Training	Registered Nurses	• 14 nurses successfully completed theoretical assignments • 3 nurses accredited for cervical cancer screening
Opportunistic screening		
Chronic Disease Training (Benchmarque)	Health professionals in Gippsland	• 53 enrolments • 15 participants: – 10 registered nurses – 3 allied health workers – 2 enrolled nurses
MBS Tailored Training for General Practice (Larter Consulting)	General practices	• 5 general practices • 36 staff combined
Other		
Gippsland PHN Webinar Series - Introduction to QI & the PIP QI	• Webinar 1 • Webinar 2 • Webinar 3	• 31 participants • 19 participants • 19 participants

Source: Initiative program reports and evaluation reports

Finding 20: There were mixed results relating to uptake of education and training activities by health professionals.

Finding 21: Except for the Latrobe Cancer Screening Collaborative which supported general practices to complete 'plan, do, study, act' cycles of

quality improvement, there was low completion of quality improvement activities among general practice.

5.3.4 Process and system re-design

There were several health system-facing activities of the initiative that focused on process redesign to support general practice identify under-screened or at-risk individuals, and system re-design e.g. trialling new models of care / clinics to increase community engagement.

Process redesign activities for primary care focused on three main activities:

- health professional education through updates to HealthPathways
- the Latrobe Cancer Screening Collaborative, and
- trial of new models of care.

Educate health professionals

HealthPathways is an online information portal for GPs and other health professionals on how to assess, manage and refer patients in the local context of available services. Throughout the Initiative, clinical and referral HealthPathways were developed for all three themes: smoking cessation, population-based cancer screening, and opportunistic screening (chronic disease). HealthPathways were developed in consultation with clinical working groups and subject matter experts including Quit Victoria, a respiratory physician, pharmacists, GPs, BreastScreen Victoria, an endocrinologist, and a diabetes educator.

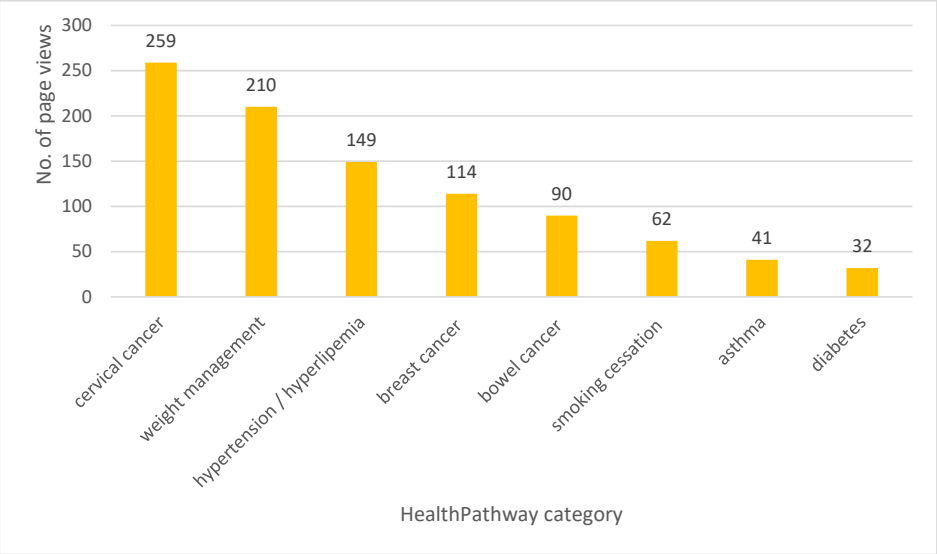
Finding 22: HealthPathways were developed on appropriate topics with input from clinicians and subject matter experts.

Over 18 months from June 2020 to December 2021 there were 62 collective page views of smoking cessation pathways, 463 collective page view of cancer screening pathways and 432 collective page views of chronic disease pathways across Gippsland. Figure 5.7 shows the breakdown of page views by HealthPathway category which indicates that *cervical cancer* and *weight management, nutrition and physical activity* were high demand pathways with over 200 views each. This indicates that GPs and other health professionals in Gippsland welcomed additional clinical or referral pathway information for these conditions.

Hypertension and hyperlipemia (149 page views) and *breast cancer* (114 page views) also received a considerable number of page views. However, there was less demand for pathways on *bowel cancer, smoking cessation, asthma* and *diabetes* (less than 100 page views each). This indicates that many GPs and other health professionals may have been comfortable with the clinical and referral pathways for these conditions already.

Finding 23: *Cervical cancer* and *weight management, nutrition and physical activity* were the most sought after HealthPathways developed, demonstrating the need for the clinical and referral pathway information among health professionals in Gippsland for these categories.

Figure 5.7: Page views of developed HealthPathways from June 2020 to Dec 2021, Gippsland



Source: Gippsland PHN HealthPathways reports

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Identify and engage under-screened / at risk individuals

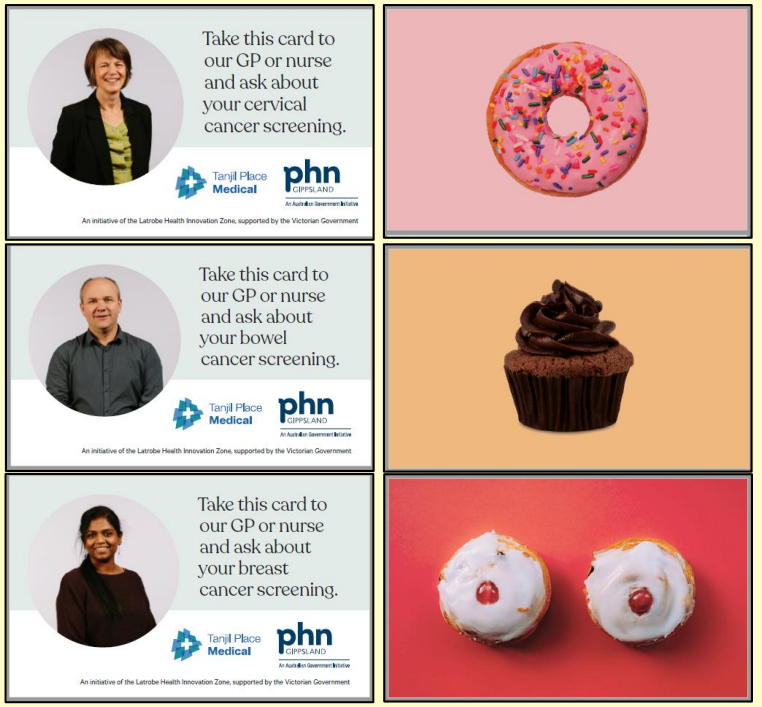
From May 2019 to February 2020, four general practices participated in the Latrobe Cancer Screening Collaborative (the Collaborative), a change-management program which focused on primary care quality improvement to support practice-led change.

Case study #3: Latrobe Cancer Screening Collaborative (the Collaborative)

The Collaborative aimed to increase patient participation rates in cancer screening programs. Cervical cancer screening was a mandatory component of the project, with all participating practices selecting bowel cancer as their second focus. Four Latrobe general practices participated in the 10-month project, which saw practices working collaboratively to develop innovative ways to increase cancer screening rates. Activities included webinars, face-to-face learning workshops (*3), and in-clinic design and implementation of projects. The project objectives were to:

- use the Improvement Foundation's *'Model for Improvement'* as a framework for developing, testing and implementing practice-led changes
- use the change principles and change ideas to implement evidence-based examples for quality improvement in the primary health care setting, and
- share ideas, resources and processes with all participants.

Each practice trialled, tested and implemented various innovative quality improvement activities based on evidence-based change principles. Successful ideas trialled by each practice were celebrated and shared with the support from Gippsland PHN to be up-scaled and implemented broader. This included: bowel screening prompt cards given to patients when attending the practice for another appointment; patient cancer screening surveys; providing phone calls to follow up or to replace reminder letters; the opportunity to increase the number of days a cervical screening nurse is available; and the implementation of Screen For Me customised clinic promotional materials with clinic staff photos and logos, encouraging patients to talk to their GP or nurse about screening (see picture).



The Collaborative also had a large focus on data collection, cleansing and analysis activities. Data cleansing was identified as a significant exercise to ensure that the data within practices clinical software information systems were complete, correct and coded properly. To ensure that data collection was accurate, updates to POLAR data extraction software routines regarding changes to national pathology bowel codes, and changes to Best Practice SQL queries were undertaken.

Key process-change outcomes of the Collaborative included:

- successful use of the Model for Improvement framework to develop and implement change
- increased confidence of practice staff to use 'plan, do, study act' cycles to test and analyse ideas before boarder roll-out

- increased understanding by practice staff of systematic approaches to quality improvement, and
- successful collaboration between participating sites to share ideas and learnings.

Practices participating in the Collaborative increased cervical cancer screening participation rates by 7.4 percentage points (from 42.3% to 49.7% collectively) and bowel cancer screening participation rates by 3.5 percentage points (from 32.7% to 36.2% collectively) during the project timeframe (June 2019 to February 2020). These results show an '*excellent*' increase for cervical cancer and a '*good*' increase for bowel cancer (as per the evaluation rubric) and demonstrate the effectiveness of the Collaborative using the Model for Improvement systematic approach.

However, practices had mixed success in engaging their practice teams and GPs in the Collaborative activities, indicating that staff confidence was not uniformly improved. In addition, data collection and cleansing were considered critical aspects for ongoing success of the quality improvement activities. The program evaluation noted that practices should be encouraged to build their confidence in practice data cleansing on a regular basis and maintain an emphasis on data coding to minimise data cleansing efforts required.

The Collaborative approach was not rolled out more broadly in Latrobe or Gippsland.

Finding 24:	The Collaborative demonstrated positive effects on cancer screening rates in participating general practices arising from process changes, but improvements in population level screening rates were not observed.
Finding 25:	Maintaining robust general practice data collection and cleansing processes were considered critical aspects of the quality improvement process and necessary for future sustainability of the program.

New models of care

Four community co-designed models of care were trialled as part of activities under the Initiative, as follows:

- **Latrobe Smoking Support Service (LSSS)**

  The LSSS was a smoking cessation / reduction program that provided free NRT to participants for one month (available via a voucher system from nominated pharmacies), along with free confidential counselling, optional prescription for additional NRT (after the first month) and ongoing support from a nurse practitioner, counsellor and peer support worker. After initial intake with a peer support worker, the participants would see the nurse practitioner and, if they chose to do so, follow on with a counsellor or continue to see the nurse practitioner. The LSSS model of care was developed using a two-step community consultation process. The first consultation focused on drivers and barriers for smoking cessation among the community to inform the development of cessation strategies that would engage smokers in the local community. The second focused on feedback to a proposed model of a smoking cessation support based on the input from the first consultation round. Key suggestions from the community consultation that were incorporated in the LSSS design were free NRT and counselling and the flexibility to choose which aspects of the program to engage with.

  The LSSS program provided clinical services for six months from July to December 2021. During this time 432 episodes of care were delivered to 117 participants, with the majority of participants (75%, n=88) attending multiple appointments (at least two), and two-thirds attending for three to four appointments (67%, n=71). Upon completion of the pilot, 21 participants (18%) had ceased smoking, and a further 67 participants (57%) had reduced smoking.

- **Student-led health check pop-up clinics**

  Three student-led health check pop-up clinics were staffed by student nurses from Federation University and delivered in shopping centres / shopping precincts across Latrobe Valley. The 15- to 20-minute health check process focused on participants' blood pressure, pulse, respiratory rate, body mass index (BMI), weight, waist measurement, height, blood glucose and cholesterol. Advice and information were given to participants as needed. At the conclusion of the health check, participants were given a copy of their results. The student-led health checks were designed based on community consultation on understanding of chronic disease prevention, exploring health literacy, understanding and perceptions of / attitudes towards early detection and screening, and community

readiness for increased opportunistic screening, including possible barriers. Key messages from the community consultation that were embedded in the pop-up clinic design were recruiting participants where they are (for example, at work or in retail environments), using people's age and life stage to start conversations about preventative health, and brief conversation.

Three student-led pop-up clinics were held between August and December 2021 and provided health checks for 188 people in the Latrobe Valley. Of the 157 participants that completed a post-check survey, 66% (n=104) indicated they would follow-up with their GP after the health check.

- **GP Outreach Health Checks**

  The GP Outreach Health Checks aimed to increase access to risk assessment and opportunistic screening of vulnerable community groups who may not otherwise participate in a health check, by providing GP sessions in places where people already gathered. Nine sessions were conducted by three general practices, in places such as libraries, Men's Sheds, neighbourhood houses and community groups. The design of an outreach clinic was based on community feedback which prioritised preventative health checks outside of general practice settings.

  A total of 56 participants were screened; one quarter were referred for follow-up care. Two of the clinics (in libraries) had no participants.

- **Nurse-Led Clinics for Risk Prevention**

  Two nurse-led clinics were established, one with a focus on women's health and risk prevention, the other on chronic disease prevention. Lead Nurses were supported to establish the clinics with on-site visits from the Australian Primary Health Care Nurses Association, induction sessions, online learning modules, and access to digital health tools and software. Lead nurses were encouraged to link into PHN resources and support related to POLAR and population health risk identification, and six health coach sessions were provided to the Lead Nurses as well as 14 other primary health nurses in the catchment. The nurse-led clinic design was based on community feedback which prioritised the optimised use of nurses in preventative health. The reason for this was two-fold: firstly, because nurses are more accessible than GPs and therefore have shorter wait times, and secondly because many community members favour nurses over GPs because nurses are local whereas doctors are often from Melbourne and have high turnover rates.

  In the eight months of operation 80 patients were seen across both clinics, 42.5% of which were referred for GP, specialist or other follow up.

The model of GP Outreach Health Check clinics was not a practical method of engaging vulnerable groups in health screening programs, and there was limited interest from General Practices in participating. At an average cost approximately $1,000 per participant, this was not considered a sustainable model of care.

Conversely, the nurse-led clinic model received positive feedback from patients. One of the two clinics indicated they would continue the nurse-led model for women's health. It was noted in the program evaluation that finding a suitable funding model to sustain nurse-led clinics would be the challenge going forward.

Finding 26: Nurse-led clinics were positively received, but the sustainability of this model will depend on identifying suitable funding models.

Three of the four novel models of care developed in consultation with community had good participation rates, suggesting that community engagement in the development process will assist in participant recruitment. However, smoking cessation was observed in less than 20% of LSSS participants (although reduction was seen in a further 57% of participants and higher cessation rates may have been observed if the program ran for longer). Similarly, although two-thirds of health check participants indicated they would follow-up with their GP, no formal referrals were made, and follow-up rates were not confirmed.

Finding 27: Models of care co-designed with the community showed good participation and satisfaction rates. However, there were insufficient data to demonstrate they resulted in beneficial patient outcomes or improved system processes in the longer-term.

Other projects that addressed new models of care were implemented under the Initiative but didn't specifically seek community participation in model of care design, as follows:

5.4 CONCLUSION

Reach of activities

The Initiative included a good mix of the types of activities undertaken across all three themes, which engaged good numbers of the community of Latrobe (and surrounding areas), albeit this was still only a small proportion of the total population of Latrobe (over 77,000 people).

Social media was a wide-reaching medium especially when cross promoted by relevant stakeholders and therefore was an effective way to promote campaign messaging.

Recommendation 4:	In future initiatives, seek information from the community on the reach of the social marketing campaigns and their effectiveness, to inform decisions regarding the value for money of the initiatives.

Vulnerable population cohorts

Vulnerable population cohorts such as Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds and LGBTIQ+ people, are more likely to experience poorer health compared to other Australians. Reasons are multifactorial and may include poor health literacy, limited access to affordable health care, cultural and language barriers and discrimination.[20][21][22]

As part of the Initiative the cancer screening theme included a number of well received activities / projects targeting Aboriginal and Torres Strait Islander people. However, there was little activity in other themes that specially addressed the needs of Aboriginal and Torres Strait Islander people. In addition, relative to the total number of projects undertaken, there were few activities that specifically targeted other vulnerable population groups. The development of new health programs and awareness raising campaigns need to include consideration of vulnerable population groups to ensure equitable health outcomes can be achieved.

Recommendation 5:	Future initiatives should include a dedicated program for vulnerable population groups.

System redesign

There was a focus within health system facing activities of the Initiative to embed quality improvement systems and processes within general practice. Quality improvement activities included 'plan, do, study, act' cycles that enabled practices to reflect processes or projects that were working well or not, based on real time data and information. As exemplified by the Collaborative project, these processes can work well and enabled participating practices to improve cancer screening rates and monitoring for their patients. However, this was a resource intensive project that required ongoing education / training for practice staff and other supports such as regular reminders about data collection, maintenance and analysis. Conversely, provision of one-off training for GPs was insufficient to promote desired quality improvement changes in general practice, exemplified by the Smoking Cessation Education training where 12 general practice attended the training, but less than half (five) completed the quality improvement activities.

This suggests that in order to be successful, system redesign processes need to be embedded slowly, and the necessary supports made available until the processes become business as usual. It also suggests that greater success could be achieved by involving staff from the whole practice, not individuals. Appropriate funding models and incentives may assist to stretch towards desired outcomes and system improvements.

Noting the pace at which redesign occurs, medium-to-longer term follow-up is required to see if benefits of training and system redesign from the Initiative were realised. Consideration of the recently released "Strengthening Medicare Taskforce Report"[23] will be important to future system redesign initiatives.

[20] AIHW report: Australia's health 2018: in brief
[21] AIHW website: Culturally and linguistically diverse Australians
[22] LGBTIQ+ Health Australia
[23] Commonwealth Department of Health and Aged Care: Strengthening Medicare Taskforce Report

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Recommendation 6:	System redesign occurs slowly and requires ongoing supports and training. Future projects need to allow sufficient time for processes to be embedded as routine practice to ensure ongoing sustainability.

Behaviour change

Much like system redesign processes, the process of behaviour change is slow paced and depends on the readiness of the individual. There are five proposed stages of behaviour change: precontemplation, contemplation, preparation, action, maintenance.[24] The time for each individual to transition through these stages will vary, as will the starting point of each person for each behaviour in question. Programs seeking behaviour change of individuals (such as smoking cessation) need to consider if people have transitioned along the behaviour change continuum as well as if the desired behaviour has been achieved / maintained. For example, a reduction in the number of cigarettes smoked per day (as observed for 57% of the LSSS participants) could be seen as a transition of the individual from a 'contemplative' to a 'preparative' state, which with further time could also transition to the 'active' state of quitting.

Recommendation 7:	Behaviour change is a slow process and individuals will vary in starting points as well as time required. Future projects should allow sufficient time / funding for medium-to-longer term effects to be observed. If this is to be combined with community co-design approaches, seven to 10 years may be a more suitable timeframe for expected behaviour changes to be observed.

Training and education

The high turnover of healthcare workers in Latrobe requires the availability of ongoing / rolling training campaigns to ensure access for new health professionals.

Recommendation 8:	Continue to provide opportunities for further training on preventative care for general practice such as standards, data optimisation, and MBS items.

[24] A sixth stage, termination, has also been proposed which would in essence start the behaviour change cycle again.

6 EFFICIENCY

6.1 SUMMARY

Activities under the Initiative engaged well with community to understand community perspectives on enablers and barriers regarding smoking cessation, cancer screening and risk and opportunistic screening. There was a strong response to community priorities identified with feedback used to develop new models of care for trial as well as tackle community awareness and understanding, and system issues such as lack of GP availability.

It is also important to acknowledge the time required to appropriately engage the community in a co-design process for new models of care. Consultation and re-consultation time are required before a model of care can be finalised, time is then required to establish the project and if necessary, recruit staff and participants before the project is implemented.

Ensuring sustainable system redesign requires engagement of local health system stakeholders. Fostering a collective approach to tackling a common issue to progress mutual objectives will be more successful than each party working independently and can reduce duplication of effort and resources. This requires a consistent data collection and shared data access to drive the desired changes. The PCG provided strong support from statewide agencies, but local engagement was comparatively lacking. As a result, integration of processes between components of the health system were not maximised.

Approximately 40% of the Initiative costs were spent on project management including salaries and wages, demonstrating the resource intensive nature of behaviour change and system redesign interventions.

6.2 EVALUATION QUESTIONS

The meta-evaluation sought to assess the efficiency of the Initiative. The key evaluation question was:

> *To what extent did the Initiative efficiently translate funding and resources into project outputs, including education the community, health promotion campaigns, educating health professionals and improved data systems?*

Detailed evaluation questions were:

Community Facing

- What was the co-design process and was it meaningful?

Health System Facing

- In what ways did the PCG advise and guide the programs, including scope, implementation and data collection?
- To what extent did data collection / sharing lead to practice change for health professionals?
- What was the approximate project cost per intervention per project output?

6.3 ANALYSIS AND FINDINGS

6.3.1 Co-design process

Implementation of themes identified from community consultation

A comparison of themes identified by community consultation and themes addressed by activities of the Initiative was undertaken. The analysis showed that most themes raised during community consultation were collectively addressed by the range of activities implemented. The main themes addressed across all activities were *raising awareness*, *increasing access* and *increasing health professional engagement.* However, themes consistently not addressed included the perceived *lack of incentive* or the *low priority* of screening (for cancer or chronic disease) or quitting smoking among the community.

Smoking cessation

There were seven main themes that emerged from community consultation regarding barriers to quitting smoking in Latrobe, as follows:

- **No incentive**: the lack of incentive to quit or quitting smoking was considered a low priority
- **Access**: the lack of access to supports to quit
- **Access to NRT**: free access to nicotine replacement therapy (NRT) was considered an enabler to quitting, implying the cost (or perceived cost) of NRT is a barrier
- **Health professionals**: the lack of health professional involvement to support quit attempts
- **Awareness**: low levels of awareness of quitting supports such as subsidised NRT or the usefulness of counselling programs such as Quitline
- **Emotional impact**: the emotional impact of quitting smoking, especially when consumers are stressed (e.g. during COVID-19 lockdowns / pandemic measures), and
- **Short-term difficulty**: while the long-term benefits of quitting were understood, the short-term difficulty in quitting was considered too great to overcome.

Three smoking cessation activities were analysed (see Figure 6.1) which showed that collectively all seven themes raised by consumers were addressed. Overall, most smoking cessation activities addressed lack of *health professional* involvement, *access* to supports to quit and *awareness* of supports available and lack of *incentive to quit*. *Access to NRT, emotional impact* and *short-term* difficulty to quit were addressed by one activity (Latrobe Smoking Support Service).

Figure 6.1: Smoking cessation activities by themes raised in community consultation

Activity / Project	Themes raised in community consultation							Total
	Health prof'al	Access	Aware	No incentive	NRT	Emotion' impact	Short-term difficulty	
Pitch to Quit Competition	Y	N	Y	Y	N			3
Pharmacy Smoking Cessation Project	Y	Y	Y	Y	N			4
Latrobe Smoking Support Service	Y	Y	N	N	Y	Y	Y	5
Total	3	2	2	2	1	1	1	

Source: Initiative program reports and evaluation reports. Activities that were not included in the analysis due to limited information were: Smoking Cessation in pregnancy, Community Quit stalls

Cancer screening

There were twelve themes raised by consumers regarding low participation in cancer screening activities and barrier that should be addressed, as follows:

- **Access**: limited access to screening services and supports
- **Education**: lack of education regarding the importance of cancer screening, smoking cessation, and risk screening
- **Fear of results**: being afraid of what the results will be
- **Awareness**: low levels of exposure to information regarding cancer/cancer screening
- **Health professionals**: limited access to health professionals (including GPs) in the Gippsland region

- **Invasion of privacy** when undertaking the screening
- **Personal experiences**: regarding health factors and comorbidities
- Previous **unpleasant experience** during screening
- **Emotional impact**: fear of the emotional impact that screening may have
- **Men reactive**: the tendency for men to be more reactive to health concerns than proactive
- Perceived **lack of incentive** to undertake screening, and
- Cancer screening being of **low priority** to consumers.

Twelve Initiative activities focused on improving cancer screening rates were included in the analysis, as shown in Figure 6.3. Collectively, all 12 themes raised by consumers were addressed by the activities. Overall, most cancer screening initiatives targeted *awareness of cancer screening* and *increasing access to cancer screening*. Providing *education* regarding screening and *incorporating health professionals into the screening process* was also addressed by a substantial number of initiatives. Activities within both rounds of Screen For Me addressed the perception that screening was of *low value*. Themes related to the *invasion of privacy*, *emotional impact* of screening, having previously had an *unpleasant experience* of screening and the tendency for *men to be reactive* and not proactive regarding health issues were only addressed by one activity each. Further, only one activity planned to address *fear of results*, but this part of the activity did not eventuate.

Opportunistic screening for chronic disease

There were four themes raised by consumers regarding barriers to accessing health checks for chronic disease testing / monitoring, as follows:

- **Access**: the lack of access to general practitioners and testing facilities
- **Health professionals**: lack of access to and involvement of health professionals
- **Education**: the lack of education regarding the benefits and importance of testing
- **Fear of results**: a fear of results from testing (including cost implications of diagnosis), and
- **Low priority**: preventing chronic disease being of low priority.

Three Initiative activities were analysed (see Figure 6.2) which showed that Five barriers were addressed by the three initiatives that were analysed. All three initiatives addressed *access* to testing and involving *health professionals* in the testing process. Two of the three initiatives addressed increasing awareness and *education* regarding testing. Only one initiative addressed consumers *fear of results*. No initiatives addressed the barrier that chronic disease testing was of *low priority* to consumers.

Figure 6.2: Opportunistic screening activities by themes raised in community consultation

PROJECTS	THEMES RAISED IN COMMUNITY CONSULTATION				TOTAL
	Access	Health professional	Education	Fear of results	
Pop up Health Checks	Y	Y	Y	Y	4
Risk Assessment and Opportunistic Screening Community Consultation	Y	Y	Y	N	3
Risk Assessment in Community Settings (GP Grants)	Y	Y	N	N	2
Total	3	3	2	1	

Source: Initiative program reports and evaluation reports. Activities that were not included in the analysis due to limited information were: Health Check Pilot, Check In on your Health Campaign.

Finding 28: Activities and projects under the Initiative addressed a good proportion of the themes and barriers raised by members of the Latrobe community during consultation. Projects consistently addressed issues relating to *raising awareness*, *increasing access* and *increasing health professional engagement* across all three focus areas: smoking cessation, cancer screening and opportunistic screening.

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Figure 6.3: Cancer Screening activities by themes raised in community consultation

Activity / Project	Themes raised in community consultation												Total
	Awareness	Access	Education	Health Professionals	Personal Experience	Lack of incentive	Low value	Invasion of privacy	Emotional Impact	Unpleasant experience	Men (reactive)	Fear of results	
BreastScreen Victoria													
Lapsed Screening Campaign	Y	Y	N	N	N	N	N	N	N	N	N	N	2
Pharmacy Campaign	Y	Y	Y	Y	Y	N	N	N	N	N	N	N	5
Aboriginal and Torres Strait Islander Women – Shawl Project	Y	N	N	N	Y	N	N	N	Y	Y	N	N	4
GP letter trial	Y	Y	N	Y	N	Y	N	N	N	N	N	N	4
Screen For Me													
Phase 1	Y	N	Y	N	Y	Y	Y	N	N	N	N	N	5
Phase 2	Y	N	Y	N	Y	Y	Y	N	N	N	N	N	5
Engaging GPs	Y	Y	Y	Y	N	Y	N	N	N	N	N	N	5
Other projects													
Cancer Screen Grant	Y	Y	Y	N	N	Y	N	N	N	Y	Y	N	6
Collaborative	Y	Y	N	Y	Y	Y	Y	Y	N	N	N	N	7

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Activity / Project	Themes raised in community consultation												Total
	Awareness	Access	Education	Health Professionals	Personal Experience	Lack of incentive	Low value	Invasion of privacy	Emotional Impact	Unpleasant experience	Men (reactive)	Fear of results	
Women's pamper day	Y	Y	Y	Y	Y	N	N	N	N	Y	N	N	6
Hazelwood project	Y	Y	Y	Y	N	N	N	N	N	N	N	N	4
Churchill 'Bust Trip'	N	Y	N	N	N	N	N	N	N	N	N	Y*	2
Total	11	9	7	6	6	6	3	1	1	3	1	1	

Source: Initiative program reports and evaluation reports. Activities that were not included in the analysis due to limited information were: Ramahyuck group booking, Ramahyuck men's business day, Ramahyuck increasing cervical screening, Gathering place bowel comedy, Multicultural engagement talks.

*Yellow colouring reflects that the project planned to address fear of results, but this did not eventuate.

6.3.2 Impact of the PCG

The PCG provided governance and advice for the Initiative, including a level of accountability for project timelines and budget (see section 7.3.1 for further detail on the role of the PCG).

However, many PCG members felt that a broader remit for the PCG membership could have resulted in greater impacts from the group.

Members of the PCG raised concerns about the group's ability to drive local influence and encourage a greater local 'collective impact' approach. PCG members commented that development of stronger local relationships and collaboration between member organisations through mutual objectives would have enhanced the potential impact of the group. One PCG member commented:

> *'Innovation requires stronger local relationships…where organisations are encouraged to work together to provide a program, change the mindset – theirs and ours. This is what's needed, this needs to happen, pull resources, skills, money, work together. Use this group as an opportunity to build relationships. You don't build relationships in a phone call every two months. Pick a project to get a few agencies to work together, stop a them/us [mentality].'*

Through the PCG, the Initiative was strongly supported by statewide agencies (e.g. Cancer Council Victoria, Quit Victoria, etc). However, many PCG members felt opportunities with local stakeholders (including Latrobe Council, Latrobe Regional Hospital (LRH), Latrobe Community Health Service (LCHS) and Latrobe Health Assembly (LHA)) to strengthen local collaboration and progress mutual objectives were not maximised.

Likewise, use of inter-agency influence to drive Initiative activities was not fostered, which was a missed opportunity for the group. Inter-agency collaborations could have assisted the development of multi-focused projects i.e. projects targeting smoking cessation and cancer screening, or cancer screening and opportunistic screening, for example. Many of the community identified barriers overlap between focus areas. Cross-promotion between areas may have been an additional way to generate community interest and participation.

Finding 29: The PCG fulfilled its terms of reference regarding governance and accountability. However, opportunities to support greater impact from the Initiative through local and inter-agency / multi-focused collaborations were missed.

In addition, there were mixed views from PCG members on the design of activities under the Initiative and the balance between innovation and evidence for projects. Some members were concerned that the PCG was too risk-averse, limiting the ability to try new approaches and hence limiting the ability to meet the innovation mandate of the Initiative and minimising local community input / context. Conversely, other members were concerned that project design decisions were being made in the absence of evidence.

Finding 30: Tension between PCG members on the balance between evidence and innovation may have reduced the potential impact of Initiative activities.

6.3.3 Impact of data collection and sharing among health professionals

Gippsland PHN support for data collection

As part of the Latrobe Cancer Screening Collaborative (see case study in section 5.3.4), Gippsland PHN engaged Outcome Health to develop a PIP QI dashboard using POLAR data that presented practice data on cervical, breast and bowel cancer screening rates. One GP practice in the Collaborative did not use POLAR, and so an alternative algorithm was created for that practice to extract data from their patient management system. The dashboard enabled Gippsland PHN to select each general practice across Gippsland individually, in any grouping, or by LGA, with comparative whole-of-Gippsland data on each display.

Finding 31: The POLAR dashboard (and alternate algorithm) has potential to be shared more broadly with general practices across Gippsland, to enable practices to routinely review their own data for quality improvement.

6.3.4 Initiative costs

The acquittal data was analysed to assess Initiative costs by themes (smoking cessation, cancer screening, opportunistic screening and administrative staffing costs), as well as by types of activities undertaken.

Figure 6.4, Figure 6.5 and Figure 6.6 on the following pages show 'actual' costs of the LHIZ Initiative per annum and in total over the five and half years (note, 2021-22 is only six months, not a full financial year).

As shown the total cost of the LHIZ initiative was $4.377 million (Figure 6.4), slightly under the budgeted $4.662 million for the Initiative (budgeted costs not shown).

The largest components of costs were for salaries and wages of Gippsland PHN staff working on the Initiative at 40% of overall costs. The proportion of costs for individual Initiative themes ranged from 17% to 24% as follows:

- cancer screening: 24%
- smoking cessation: 20%, and
- opportunistic screening: 17%.

Cost per theme was analysed by the number of activities / projects undertaken per theme. This equated to an approximate average of $64,000 per activity / project for the 41 activities undertaken in the Initiative (Figure 6.5). However, the nature of individual activities / projects varied greatly, from focus groups for community consultation, to the Screen For Me community awareness campaign or the LSSS smoking cessation clinic. Actual costs for individual projects was not available for analysis.

Finding 32: The cost of the Initiative was $4.4 million over five and a half years. This equated to an average cost per activity / project of approximately $64,000.

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Figure 6.4: LHIZ Initiative cost per annum

Cost category	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22*	Total	
							$	%
Salaries & Wages^	$12,812	$232,682	$435,843	$452,193	$488,164	$121,983	$1,743,677	40%
Smoking Cessation	$36,000	$207,021	$97,724	$211,674	$228,031	$84,167	$864,617	20%
Cancer Screening	$0	$146,705	$443,942	$212,184	$115,948	$121,618	$1,040,396	24%
Opportunistic Screening	$0	$30,822	$101,671	$152,497	$201,645	$242,191	$728,825	17%
Total	**$48,812**	**$617,231**	**$1,079,179**	**$1,028,547**	**$1,033,787**	**$569,959**	**$4,377,516**	**100%**

Source: Gippsland PHN acquittal data for the LHIZ Early Detection and Screening Initiative Including Tobacco.
*2021-22 is only six months (July to December 2021), not a full financial year.
^Salaries and Wages includes stakeholder liaison and engagement costs which totalled $2,639 over the life of the Initiative.

Figure 6.5: Average LHIZ Initiative cost activity project

Activities/ Projects	Research	Community facing	Health facing	Total	Cost	Avg cost
Smoking cessation[1,3]	3	2	7	12	$864,617	$72,051
Cancer screening[2,3]	5	7	6	18	$1,040,396	$57,800
Opportunistic screening[3]	2	3	6	11	$728,825	$66,257
Total	10	12	19	41	$2,633,838	$64,240

Source: Initiative program reports and evaluation reports, Gippsland PHN mid-term reports., Gippsland PHN acquittal data for the LHIZ Initiative.
1: Both rounds of Pitch to Quit were counted as one project
2: Activities undertaken by BSV were counted as two projects (Gippsland Strategy and Improving Breast Screening Participation within Gippsland PHN), Screen For Me was counted as two projects for community facing activities (general activities and Community Grants) and one project for health system facing activities.
3: All three overarching projects (HealthPathways, POLAR dashboard and Social Network Analysis) were counted as health system facing in all three themes
A list of projects per theme and activity type is provided in Chapter 2.

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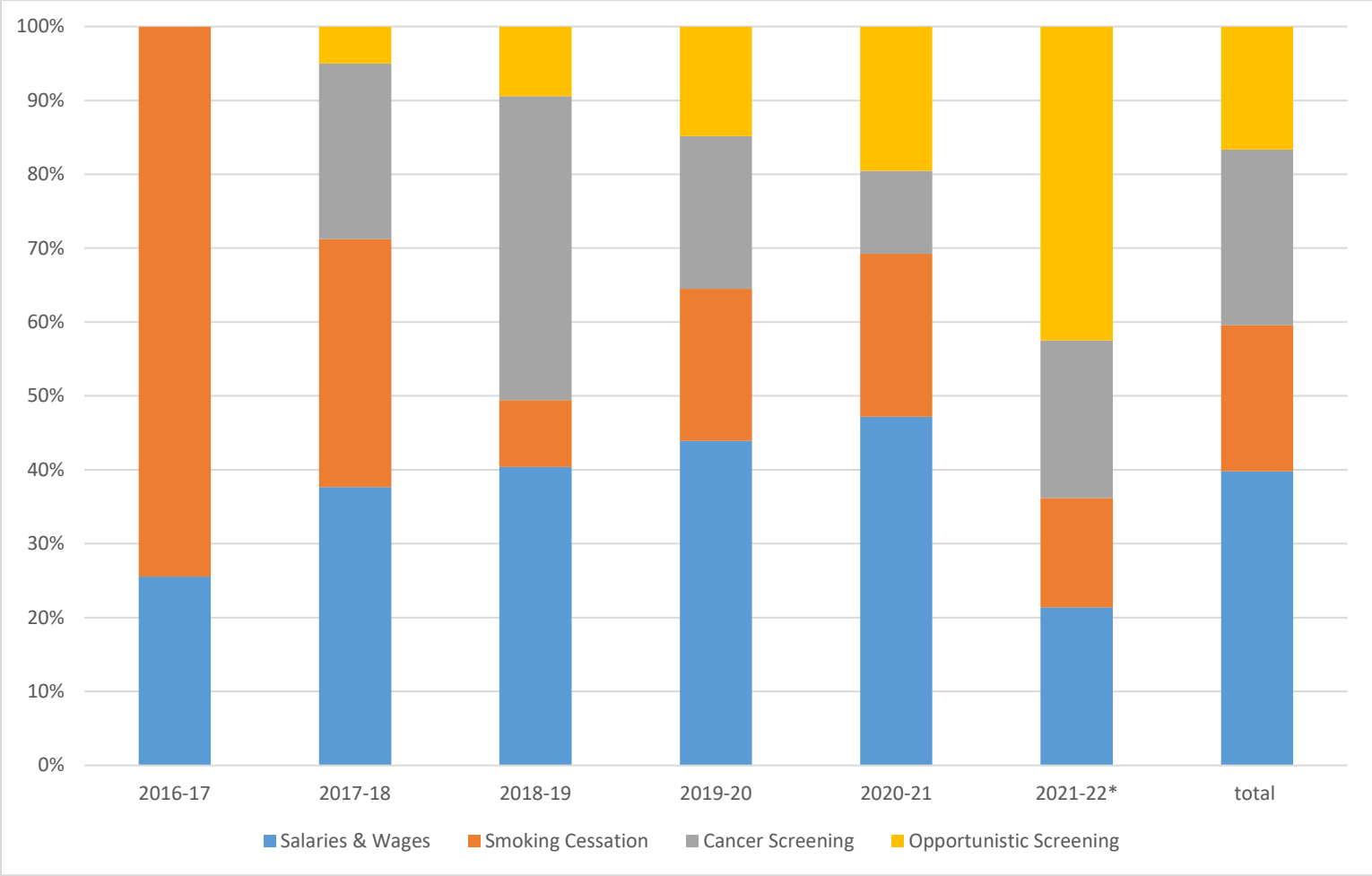
Figure 6.6: Initiative costs by category per annum



Source: Gippsland PHN acquittal data for the LHIZ Early Detection and Screening Initiative Including Tobacco.
*2021-22 is only six months (July to December 2021), not a full financial year.

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Finding 33: The largest cost category was staff salaries and wages at 40% of total costs, with the remaining 60% spent on the three themes of the Initiative (approximately 20% per theme).

Implementation costs of Initiative activities and projects were also categorised by Gippsland PHN under five activity types, as follows:

- (A) Partnership development and stakeholder liaison
- (B) Building systems capability and capacity
- (C) Health system modification
- (D) Building knowledge through education, and
- (E) Monitoring.

Figure 6.7 summarises the Initiative implementation costs per activity type, which shows most funding was spend on *building systems and capability / capacity* (39%) and *partnership development and stakeholder liaison* (25%) activities. Very little was spent on *monitoring activities* (2%).

Figure 6.7: Initiative costs by activity type, total

Activity type	Total	
	$	%
(A) Partnership development and Stakeholder Liaison	$654,999	25%
(B) Building Systems Capability and Capacity	$1,032,425	39%
(C) Health System Modification	$473,132	18%
(D) Building Knowledge through Education	$417,672	16%
(E) Monitoring	$55,611	2%
Total	**$2,633,838^**	**100%**

Source: Gippsland PHN acquittal data for the LHIZ Early Detection and Screening Initiative Including Tobacco.
^ Staff salaries and wages not included.

A further break down of costs by activity per annum is presented in Figure 6.8 on the following page. This demonstrated a growth in spending on *building systems and capability / capacity* and *building knowledge through education* throughout the life of the Initiative.[25] As anticipated, the majority of funding for *partnership development and stakeholder liaison* was spent in the first half of the Initiative and tapered off in the latter half. There was growth in *health system modification* spending until 2020-21, reflecting the onset of the COVID-19 pandemic.

Finding 34: There was a mix of implementation activities on which Initiative funding was spent, with close to 40% being spent on *building systems and capability / capacity* over the life of the Initiative.

[25] Note a slight decrease in 2021-202 owing to only six months of data for this year.

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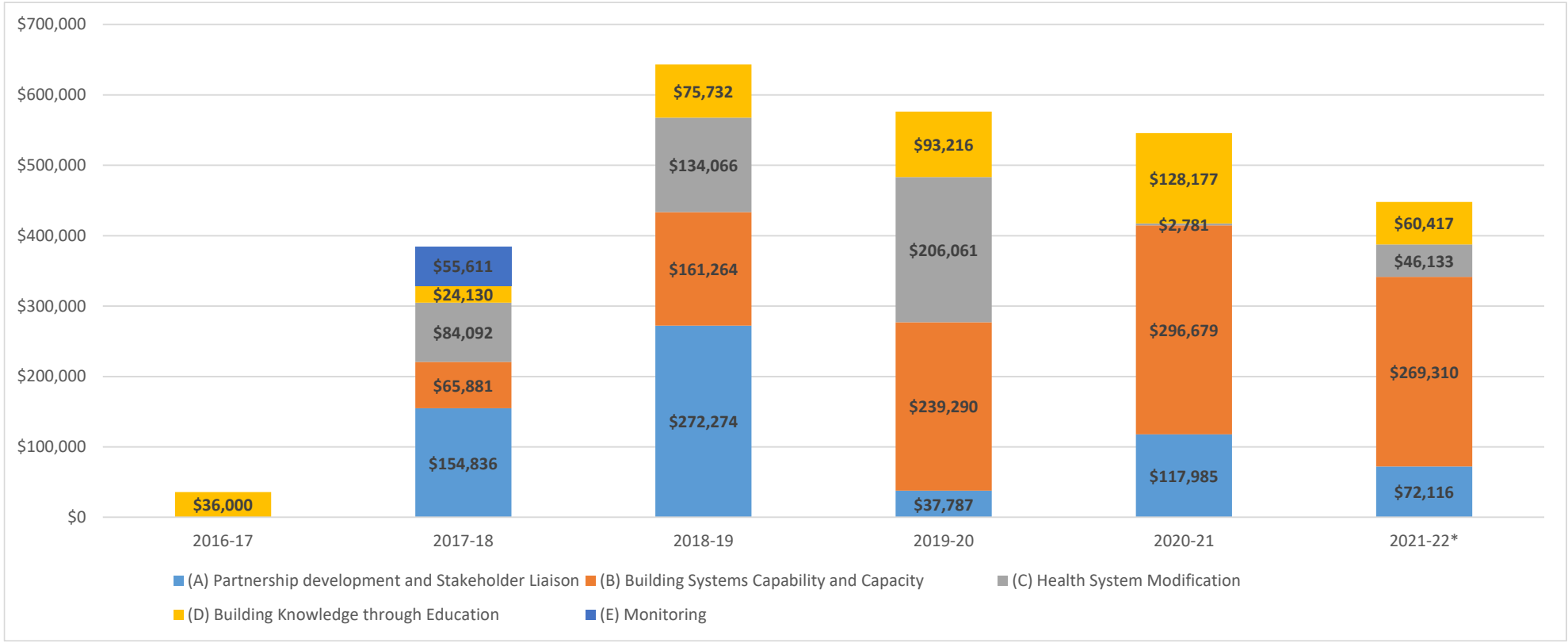
Figure 6.8: Initiative costs by activity type per annum



Source: Gippsland PHN acquittal data for the LHIZ Early Detection and Screening Initiative Including Tobacco.
*2021-22 is only six months (July to December 2021), not a full financial year.

6.4 CONCLUSION

Co-design

Activities under the Initiative engaged well with community to understand community perspectives on enablers and barriers regarding smoking cessation, cancer screening and risk and opportunistic screening. There was a strong response to community priorities identified with feedback used to develop new models of care for trial as well as tackle community awareness and understanding, and system issues such as lack of GP availability.

All barriers raised by community members were addressed in at least one activity / project of the Initiative across all three themes. The most common barriers addressed for all three themes were awareness, access to health professionals and education for community members and health professionals.

However, only one project appeared to undertake multiple rounds of consultation with community in the process of developing a new model of care – LSSS. Enabling community to not only identify enablers / barriers, but to provide comment on the proposed model of care and how it addresses their needs is important to ensure a successful program. Likewise, the co-design process also needs to engage health professionals to ensure proposed models align with existing work practices and has health professional support.

It is also important to acknowledge the time required to appropriately engage the community in a co-design process for new models of care. Consultation and re-consultation time are required before a model of care can be finalised, time is then required to establish the project and if necessary, recruit staff and participants before the project is implemented.

Recommendation 9:	Future co-design projects need to allow for multiple rounds of input from community members and health professionals. Projects should allow for lead in time for co-design processes.

Enhancing the role of the PCG

Ensuring sustainable system redesign requires engagement of local health system stakeholders. Fostering a collective approach to tackling a common issue to progress mutual objectives will be more successful than each party working independently and can reduce duplication of effort and resources. This process needs to include consistent data collection and shared data access to drive the desired changes. While the PCG provided strong support from statewide agencies such as Cancer Council Victoria and Quit Victoria, local engagement was comparatively lacking. As a result, integration of processes between components of the health system may not have been maximised (e.g. only 30% of referrals to the LSSS were from health professionals outside of the Latrobe Community Health Service (project implementors).

Recommendation 10:	In future, exploration into mechanisms to enable the PCG (or similar group) to drive local influence need to be explored. This could be through greater local stakeholder engagement with groups like the PCG or consideration of using a collective impact approach to generate local buy-in.

When implementing new models of care or other activities to improve health outcomes, it is important that the models be based on the available evidence. This ensures the activity has potential to generate the desired outcomes. However, this needs to be balanced with insights from the community on local needs and stages of behaviour change. Tailoring interventions to local areas needs to be cognisant of differences in local attributes compared to the evidence base, such as average distance travelled to access health care, costs of health care relative to income, education levels and health literacy levels. In an academic sense, tailoring programs may be seen as less rigorous or diminishing the potential benefits gained. But tailoring drives engagement and participation from the local community, and 'diminished' benefits are still an improvement on 'no' benefit, which is the outcome if communities will not engage.

Noting the tension reported between PCG members on the use of innovation versus the evidence base for project design, it is important that the PCG

membership of subject matter experts, local healthcare providers and community representatives is balanced.

Recommendation 11:	In future, an even balance of subject matter experts, local healthcare providers and community representatives is required for advisory and control groups.

Costs

Approximately 40% of the Initiative costs was spent on salaries and wages for project resourcing. This demonstrates the resource intensive nature of behaviour change and system redesign interventions.

Further information on individual project costs is needed to determine value for money of individual projects. Additional data on medium- to longer-term outcomes are also required to determine the value for money of the Initiative overall.

Monitoring and evaluation data

The Initiative aimed to generate community wide behaviour change with supported system redesign across three heath priorities: smoking cessation, cancer screening and risk and opportunistic screening. Many of the activities / projects implemented were novel ideas designed to meet the needs of the local community, or activities targeted specific sub-groups of the catchments e.g. specific age ranges or postcodes. As such, ensuring data availability for the monitoring of project outcomes was critical for assessing the overall impacts of the Initiative. This includes collecting periodic data throughout the implementation period to enable progressive monitoring and adjust as required.

While much data can be obtained from public data sources such as AIHW, there is often a lag period before data are published to ensure data accuracy. In some instances, the lag period can be up to two-years. It is important to allow for such delays in planning evaluation activities, and possibly even longer if long-term impacts are to be assessed.

Publicly available data are typically presented at state and PHN levels and often at smaller geographic levels such as SA3. However, specific requests are required to obtain more nuanced data such as by postcode or by Indigenous status. In some instances, data for evaluation may be held by a third party but not typically published. In these instances, provision in the evaluation needs to be made for data requests to third parties to obtain the necessary information.

Recommendation 12:	Future programs need to ensure that requisite data for monitoring and evaluation purposes is available. Where appropriate, lag time for public data availability should be factored into evaluation timeframes.

7 APPROPRIATENESS

7.1 SUMMARY

The aim of the Initiative was to generate synergistic achievements through collaboration and united goals, inter-agency approaches, and activities tailored to the needs of local community. Across all three themes of the Initiative, projects were undertaken that focused on engaging the community, as well as projects that sought to engage health professionals and system re-design. However, an overarching approach that linked health system and community facing activities together was not applied. This reflected in the omission of a dedicated planning phase to the overarching concept of the Initiative, which saw early activities / projects delivered without community consultation and often with poorer results.

Activities within the Initiative approached each of the three themes separately despite the crossover of the target audiences (both in the community facing and in the health system). There are system issues that present barriers common to all three themes such as awareness of services and suitable referral processes, collection and analysis of data to identify at risk individuals, and overdue reminder processes. Establishing processes to tackle common barriers that can be applied to multiple themes will reduce duplication of effort. Similarly, community consultation identified many common barriers across themes such as fear of results, perceived low value of screening and lack of incentive.

Uptake of training and education offered to health professionals was overall lower than anticipated. The COVID-19 pandemic contributed to an overwhelmed health system, significant primary care fatigue and workforce turnover.

7.2 EVALUATION QUESTIONS

The meta-evaluation sought to assess the appropriateness of the Initiative. The key evaluation question was:

> *To what extent was the Initiative design appropriate for the target population and context?*

Detailed evaluation questions were:

Governance

- Was the governance structure, the PCG, appropriate?

Community Facing

- Were community members, including vulnerable groups engaged in the co-design and were the engagement strategies appropriate?
- Were the modalities used to promote the initiatives / social marketing appropriate?
- What was the balance of locally developed marketing and existing products? Was this appropriate?

Health system facing

- Which types of health professional were the training programs targeting?
- What modalities were available and was this suitable?
- What was the balance of tailored and 'off the shelf' products? Was this suitable for the local scenario?
- What other activities were undertaken to support health professionals?

- Was there adequate opportunity for feedback on the training and could training be adjusted accordingly?

7.3 ANALYSIS AND FINDINGS

7.3.1 Appropriateness of the PCG

The PCG membership had representation from funders, local council, local service providers, subject matter experts and community representatives, with representatives from the following organisations:

- the Victorian Department of Health and Human Services (DHHS, now the Department of Health)
- Gippsland PHN
- Latrobe Regional Hospital (LRH)
- Latrobe Community Health Service (LCHS)
- Cancer Council Victoria (CCV)
- BreastScreen Victoria (BSV)
- Quit Victoria
- Victorian Chronic Disease Primary Alliance (representative from the Heart Foundation as a member organisation of the Chronic Disease Primary Alliance)
- Latrobe Health Assembly (LHA)
- Latrobe City Council
- Latrobe community representative, and
- Gippsland Women's Health (GWH).

Consultation with the PCG membership in 2019 demonstrated that the membership had a good mix of local stakeholders and subject matter expertise. However, there were some suggestions for additional PCG members that would strengthen the community voice and community-facing activities, including:

- Lifestyle modification programs (e.g. Life!)
- Gippsland Women's Health (subsequently engaged as a member, but only attended one meeting)
- Gippsland Multicultural Service
- Local organisations representing Aboriginal and Torres Strait Islander people
- Local non-government organisations, and
- Central West Gippsland Primary Care Partnership (PCP) for a prevention perspective. Note, the PCP is no longer operational, and the Gippsland Regional Public Health Unit (established during the COVID-19 pandemic) has taken over some of the role of the PCP.

Finding 35: The PCG membership had a good mix of relevant organisations. Further engagement with additional local service providers may have been beneficial, especially organisations for Aboriginal and Torres Strait Islander people and culturally and linguistically diverse people.

Membership engagement levels

As shown in Figure 7.1 on the following page, the PCG membership met 32 times from inception of the Initiative (February 2017) to completion (June 2022). PCG meetings were scheduled more frequently (almost monthly) in the first 18 months of the Initiative, before moving to every two months from mid-2018 onwards (with breaks over the summer / holiday period). There was a gap in scheduled meetings at the beginning of 2020, reflective of the uncertainty at the beginning of the COVID-19 pandemic.

Finding 36: There was ample opportunity for PCG members to be informed and to contribute to the Initiative, especially during the developmental stages in the first 18 months of the project.

Finding 37: During COVID, the PCG meetings continued (predominately via teleconference), providing opportunities for collaboration and consultation during this time.

Aside from Gippsland PHN, DHHS and the Heart Foundation (as representative for the Victorian Chronic Disease Primary Alliance) were the most engaged PCG members, attending 88% of scheduled meetings. This was followed closely by LCHS, CCV, LHA and Quit Victoria (for which representatives attended 66% of meetings), and BSV and community representatives attended 63% of meetings.

7 APPROPRIATENESS

Less engaged representatives were LRH (attending approximately half of the scheduled meetings, 47%), Latrobe City Council (attending 22% of meetings) and Gippsland Women's Health (attending only one meeting, 3%).

Although attempts to obtain higher engagement from the hospital were made, LRH became a non-active member once the COVID-19 pandemic occurred in early 2020.

Finding 38: Engagement of PCG members varied by organisation, although the majority (75%) of members attended more than 60% of PCG meetings.

Role of the PCG

There were mixed views among PCG members about the clarity of the PCG role and the appropriateness of PCG activities. Half of the membership felt that the PCG structure was suitable and the role (governance, expert opinion, guide direction and ensuring the Initiative was meeting deliverables) was appropriate. Conversely, half of the membership felt that the terms of reference for the PCG were unclear and would have liked further guidance on whether the PCG should:

- provide an advisory /guidance role or if the group had authority to make decisions
- review Initiative progress or contribute to activity implementation, and/or
- advise on governance structures (e.g. a forum to raise issues, risk and opportunities) or provide oversight of activities.

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Figure 7.1: PCG meeting frequency and attendance by membership representatives

PCG member	Attendance (32 mtg) n	%	2017	2018	2019	2020	2021	2022
Gippsland PHN	32	100%						
DHHS	28	88%						
Heart Foundation*	28	88%						
LCHS	23	72%						
CCV	21	66%						
LHA	21	66%						
Quit Vic	21	66%						
BSV	20	63%						
Community representative	20	63%						
LRH	15	47%						
Latrobe City Council	7	22%						
GWH	1	3%						

Source: Gippsland PHN data on PCG meeting attendance. *Heart Foundation was representing the Victorian Chronic Disease Primary Alliance

	Attended meeting (either in person or via teleconference)
	Absent from meeting
	No meeting / not invited

Some PCG members commented that role of the PCG had become less clear as the Initiative progressed. It was felt the role had shifted from governance, advice and rigorous feedback to an endorsement function.

Finding 39: Further clarity on the role/s of the PCG would have assisted group operations and enhanced the effectiveness of the group as a whole.

Some PCG members commented that decisions were made out of session, which may not have included input from all members. It was felt that there was a division between what happened in PCG meetings (influence and monitoring progress) and what occurred outside the group format (design, implementation, resources). This limited the utility of the expertise of the whole PCG membership, and the group's ability to provide a robust governance role. Many PCG members would have appreciated greater opportunity to input into the implementation of activities as a 'think tank', e.g. providing advice or ideas on how to promote projects, drive innovation, stage implementation activities etc.

Finding 40: The PCG appropriately provided governance and accountability for the Initiative, however clearer Terms of Reference may have helped respond to evolving expectations of members.

Responsiveness to PCG input

PCG members felt that, as Initiative coordinators, Gippsland PHN were responsive to PCG ideas and feedback. For example, PCG suggestions for additional information to develop a greater understanding about smoking cessation in Latrobe Valley were implemented via a qualitative research project.

Finding 41: PCG membership felt that many PCG suggestions and feedback were acted upon with due consideration.

7.3.2 Community engagement in development of local strategies

The majority of community engagement for co-design of projects within the Initiative were conducted face-to-face as shown in Figure 7.2. This included a mix of workshops, small focus groups and verbal survey (face-to-face for cervical screening and phone based for opportunistic screening). Only two written surveys were undertaken (one of men's shed participants on bowel cancer screening, and one of community members for opportunistic screening). Most community engagement activities focused on smoking cessation and cancer screening.

Figure 7.2: Community engagement for project co-design

Disease focus area	Interviews / focus groups / workshops	Surveys
Smoking cessation	Unknown: Workshop – 30 participants 2019: Smoking cessation, 15 focus groups – 85 participants 2020: smoking g clinic, 3 focus groups – 19 participants	-
Cancer screening	2017: focus groups for bowel and breast cancer – unknown number of participants 2018: Cervical cancer (verbal survey) – 93 participants 2018: Vox pops – 10 participants 2019: 14 focus groups for breast, bowel and cervical cancer – 80 participants	Bowel cancer survey – 18 respondents
Opportunistic screening	2021 individual interviews and group discussions – 124 participants Interviews reached Aboriginal and Torres Strait Islander people using ACCHOs as interview venue and culturally and linguistically diverse communities including: Serbia, India, Pacific Islands, Pakistan, Philippines, Malaysia, Romania, Lebanon, Kenya and South Africa.	Survey – 44 respondents

Finding 42: Community engagement to co-design Initiative projects was undertaken using mixed methods including face to face workshops / focus groups, verbal and written surveys, in person or telephone interviews and vox pops.

Finding 43: Aside from the Opportunistic Screening consultation process, there was limited community engagement with vulnerable populations

groups (such as Aboriginal and Torres Strait Islander people or culturally and linguistically diverse people) to identify any specific needs or barriers.

Of the community engagement activities undertaken, most focused on ascertaining community perceptions and current barriers for the three focus areas of the Initiative: smoking cessation, cancer screening or health checks / opportunistic screening. For the most part, this level of consultation was undertaken to inform development of projects.

Of the three focus areas of the Initiative, only smoking cessation conducted a two-step approach to community engagement. This supported development of the Latrobe Smoking Cessation Clinic (see 'new models of care' in section 5.3.4 for more details on this project). However, feedback was also sought for the proposed concept of the Screen For Me cancer screening initiative (see case study #2 in section 5.3.1) and the student-nurse-led health check pop-up clinics (see 'new models of care' in section 5.3.4), prior to finalisation.

Finding 44: The Initiative sought community input in order to tailor activities to the needs / circumstances of the local community. However, additional follow-up with community members could have been undertaken to ensure designed projects would be acceptable within the community, and that implementation of interventions was progressing appropriately.

Appropriateness of promotional materials

A CATI of Latrobe residents was planned to assess the effectiveness of promotional activities under the Initiative, including social marketing., The CATI was not undertaken as planned, limiting a broader assessment of promotional materials and the balance of social media and other modalities.

7.3.3 Health professional training

A range of training activities were implemented under the Initiative across all three focus areas (smoking cessation, cancer screening, opportunistic screening / health checks).

Training programs that collected post-training feedback showed overall satisfaction with training provided (Smoking cessation education and Cervical Screening Test (CST) Training Courses). However, feedback was not collected for all training programs and there were low participation rates for training activities overall.

Low participation rates may have been due to multiple factors such as:

- **Length of training courses**. For example, the evaluation of the Smokefree Gippsland course indicated:

  '…the training module and accompanying PDSA activities are lengthy and time consuming for people whom are working in a very fast-paced environment. To increase the uptake of the brief advice training, and accompanying PDSA activities, simplifying and reducing the intensiveness of both would increase the appeal this package has in general practice.'

- **Timing of training implementation**. For example, during the COVID-19 pandemic, health professionals were fatigued and less likely to engage in training activities.

Two thirds of training offered under the Initiative was implemented face-to-face. Three training programs were offered online: Program (PIP) Quality Improvement (QI) incentive training for the Collaborative project and the Smokefree Gippsland program, and the Chronic Disease Training delivered by Benchmarque. The Smokefree Gippsland program was offered both as a face to face and online program, with low uptake for both. This indicates that the modality is unlikely to be the cause of low participation rates by health professionals.

However, training participation within Initiative projects was high. For example, practice staff from all five GP Practices participating in the Collaborative attended the training webinars provided. This suggests that an understanding of the importance of training topics or a pre-existing commitment may be enablers for participation.

Two thirds of training programs were targeted towards general practice (GP and/or practice nurses), although some programs targeted a rage of health professionals such as Chronic Disease Training delivered by Benchmarque and the Smoking Cessation Education training sessions. Two programs were targeted specifically towards pharmacists (Quit 'Talk to your Pharmacist' campaign and BreastScreen Victoria Pharmacy Campaign) and one towards registered nurses (Cervical Screening Accreditation Training).

There were no training programs focused on system-wide processes such as multidisciplinary collaboration, providing consistent messaging to consumers or understanding referral pathways.

Finding 45: The Initiative offered limited training programs for health professionals outside of general practice.

7.4 CONCLUSION

Generating synergistic impact

The aim of the Initiative was to generate synergistic achievements through collaboration and united goals, inter-agency approaches, and activities tailored to the needs of local community. Across all three themes of the Initiative, projects were undertaken that focused on engaging the community, as well as projects that sought to engage health professionals and system re-design. However, an overarching approach that linked health system and community facing activities together was not applied.

Only one project – the Collaborative – demonstrated a link between system redesign (through general practice quality improvement activities for cancer screening) and community facing activities (Screen For Me social marketing campaign). In this flagship project, tailored Screen For Me promotional materials were developed for participating practices. From a community perspective this provides consistent and reinforcing messaging. The Collaborative also timed activities with national cancer awareness months, thus proving opportunities to link into broader health system resources and information also.

Lack of connection between projects is reflected in the omission of a dedicated planning phase to the overarching concept of the Initiative (as opposed to planning of individual projects). In attempts to 'hit the ground running', projects commenced in the first year of the Initiative without community consultation and without sufficient tailoring to the local environment. For example, the Pilot of the Integrated Risk Assessment Tool for Chronic Disease was undertaken in 2017, before there had been time to undertake any community consultation. The evaluation of this program found that not only was there poor uptake (demonstrating that it was not addressing barriers experienced by the community), but unexpected consequences also included lack of recognition and understanding of their potential risk, thus removing incentives for change and potentially delaying accessing medical care.

A program of the complexity and magnitude of the LHIZ Initiative would have benefited from a dedicated planning phase that allowed appropriate community and health professional consultation. Planning would have allowed Gippsland PHN and the PCG to consider the interface between the community facing and health system facing activities.

Recommendation 13: Future undertakings in this space need to allow adequate planning time to ensure identified barriers are approached from both the community and health system perspectives for synergy and greater potential impact.

Activities within the Initiative approached each of the three themes separately despite the crossover of the target audiences (both in the community facing and in the health system). This approach was suitable for many of the activities undertaken, for example the messaging of the social marketing campaigns were appropriately targeted to one theme only.

However, noting that the same health professionals were being targeted for many of the referral pathways, information provision and quality improvement activities, more could have been done to combine messaging for all three themes at this level. There are system issues that present barriers common to all three themes such as awareness of services and suitable referral processes, collection and analysis of data to identify at risk individuals, and overdue reminder processes. Establishing

processes to tackle common barriers that can be applied to multiple themes will reduce duplication of effort.

Similarly, community consultation identified many common barriers across themes such as fear of results, perceived low value of screening and lack of incentive. Preventative health literacy campaigns for community members could target common barriers and include relevance for multiple themes at the same time.

Recommendation 14:	Future programs should investigate suitable mechanisms to include cross promotion between themes and apply system-wide redesign approaches across multiple themes where appropriate.

Health professional training

Education and training can promote behaviour and systems change among health professionals. However, the overall uptake of education and training programs by health professionals as part of the Initiative was low, likely due to the significant impact of the COVID-19 pandemic and overwhelming fatigue in primary care.

'Off the shelf' training products appeared less popular among health professionals than those that were specifically tailored. Understanding the reasons for low uptake is critical to generating greater engagement in future programs and demonstrates the need to engage health professionals in co-design of training programs also.

Consideration needs to be given to training content and ensuring its relevance, length of the course relative to perceived importance and benefit, timing in relation to other priorities, and format – online, face-to-face or both. Consideration may also need to be given to incentivising health professionals to undertake training. In primary care many health professionals are in private practice. Therefore, participating in training activities impacts on the ability to generate income.

Similarly, although 14 nurses successfully completing the theoretical components of the Cervical Screening Accreditation Training, only three nurses were accredited for cervical cancer screening at the end of the Initiative. Noting the shortage of GPs in Gippsland, upskilling nurses to undertake cervical cancer screening was a critical step in improving access for women in Latrobe and Gippsland more generally Further investigation into the low translation rate is required.

8 SUSTAINABILITY

8.1 SUMMARY

There are learnings / activities from individual projects that will be maintained beyond the Initiative. However, limited data to determine if projects were value for money combined with lack of sustainable funding options hindered the establishment of new models of care in routine business practices.

Embedding quality improvement process takes time and with high workforce turnover needs ongoing support and resources for health professionals to implement.

8.2 EVALUATION QUESTIONS

The meta-evaluation sought to assess the sustainability the Initiative outcomes or projects. Key evaluation question was:

> *To what extent did the Initiative contribute towards sustainable capacity with funding or policy support?*

Detailed evaluation questions were:

Health System Facing

- Will the PCG continue to collaborate on smoking cessation, cancer screening and opportunistic screening now the Initiative has ceased?
- What elements of the initiative, if any, are still in place, or expected to continue?
- What has occurred / needs to occur to embed QIP?
- What are the barriers and enablers to a broader roll out or long-term sustainability, including training and education required to sustain routine practice change?

8.3 ANALYSIS AND FINDINGS

8.3.1 Ongoing strategic input

The PCG has not continued in another format since the completion of the Initiative at end June 2022. Although many members of the PCG expressed interest in greater involvement in project implementation mid-way through the Initiative, the group has not continued in any formal way. However, it must be noted that the PCG interviews occurred before the COVID-19 pandemic, and member priorities and availability may have changed since this time.

During interview, PCG members commented on the lack of accountability for the PCG membership, which resulted in greater engagement from some members more than others.

At a strategic level there was also limited engagement from local council, local service providers and other local stakeholders. Generating an ongoing momentum within the local community requires engagement from stakeholders on the ground, which wasn't achieved during the Initiative. This should be interpreted in light of the broader context of the establishment of the other aspects of the Latrobe Health Innovation Zone – Latrobe Health Assembly and Latrobe Health Advocate.

The PGC membership (weighted to external subject matter experts) and defined role (governance and accountability for timelines and budget) did not foster the local engagement and drive required to continue beyond the timeframe of the Initiative. Nor did it promote interagency collaboration or project design to foster trial of cross-promotion / holistic approaches for the three themes of the Initiative.

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A collective impact approach to generate greater buy-in from local stakeholders (with accountability embedded) may have been a more useful approach to generate longer term sustainability at the strategic level. Collective impact is a framework for change using a collaborative approach to address complex social issues. It comprises five conditions: a common agenda; continuous communication; mutually reinforcing activities; backbone support; and shared measurement. Collective impact approaches can drive synergistic outcomes through mutual input and agreement of the membership at an organisational level. The nature of primary health care (many private practices) may present its own challenges in this instance.

8.3.2 Sustainability of processes and activities

Although the Initiative did not yield the synergism and impact originally desired, there were positive elements to some of the projects / activities undertaken that will continue. For example:

(1) The cultural breast screening shawl developed by BSV in collaboration with Ramahyuck and VACCHO was received positively among Aboriginal and Torres Strait Islander women and will be continued by BSV. Based on the success of the shawl project, BSV will explore a similar project for culturally and linguistically diverse women also.
(2) The trial of various reminder letters / phone call for overdue screeners by BSV provided information on when to use more costly phone call reminders, versus less expensive SMS or letters. This information will help them efficiently target women overdue for a breast screen in in future.
(3) The training of nurses to undertake cervical screening will improve access to cervical screening in the region. In addition, the program increased the number of preceptors that can approve nurse placements. This will make future training more accessible in Gippsland.
(4) The HealthPathways developed as part of the Initiative have received numerous views and will be an ongoing resource for health professional in the region.
(5) The POLAR dashboard developed as part of the Collaborative will remain an informative source of data for Gippsland PHN.
(6) General practices that participated in quality improvement activities will maintain the quality improvement (e.g. plan, do, study, act) skillsets which can be implemented broadly.

Other activities such as the Churchill Neighbourhood Centre Bust Trip that arranged a local bus to take women for breast screens, provide low-cost options to improve access for people and create a positive, peer-supported experience around cancer screening. This type of activity could be easily maintained for minimum effort and cost.

However, there are no plans to continue with other projects / activities, due to insufficient outcomes data or lack of funding. For example:

(1) Awareness raising campaigns such as Pitch to Quit (smoking cessation) and Screen For Me (cancer screening) used social media as a mechanism to reach a broad range of people at low cost. Further analysis of the impact of these campaigns on the community (i.e. awareness, recall and behaviour change) is required to determine if they are achieving their objectives and worth continued investment. Regardless, both of these projects have left legacy media resources including personal stories and quit advertisements that will remain available.
(2) New models of care trialled such as the LSSS and the student-led pop-up health checks had mixed outcomes. LSSS observed a decrease in smoking among participants, but a low percentage that ceased smoking during the program timeframe. The student-led clinics were positively received but didn't make formal referrals to link participants into the health care system. Neither program was established with a sustainable funding model, nor explored possible funding models that could enable sustainability.

Finding 46: There are learnings / activities from individual projects that will be maintained beyond the Initiative. However, larger scale systemic changes were not observed. New models of care were not established with sustainable funding models, making it difficult to continue once the Initiative funding ceased. Lack of community data on the impact of awareness raising campaigns and behaviour change because of the Initiative hinders assessment on whether programs are worth continued investment. Lack of project cost data or cost-benefit

analysis for most activities prevents any robust assessment on the value of projects undertaken under the Initiative.

8.3.3 Embedding QIP

The Collaborative was a flagship project under the Initiative and demonstrated uptake of quality improvement activities within general practice, improved discussions about cancer screening and improved screening rates for the participating practices. However, this was a resource intensive project to administer with practices requiring high levels of support to complete the quality improvement activities. Without the ongoing support, it is unknown if the practices will continue with the quality improvement activities.

Finding 47: The Collaborative model was considered useful to bring about change in a clinical setting, but this was dependant on funding support for clinics to participate in intensive quality improvement activities.

The Collaborative evaluation noted that implementing improvements at a general practice level requires a comprehensive approach to quality improvement which engages multiple stakeholders, encourages a culture of knowledge sharing, the general practice team, as well as acknowledging differences in local contexts. The Model For Improvement worked best when all clinic staff engaged with the process, and when there was a clinic Champion to keep momentum. The importance of the time to test, analyse and reflect on activities was also noted as a key factor in the success of the model.

Quality improvement activities are also dependant on the quality of the data collected and hence an emphasis on data collection and cleansing is essential. In addition, the POLAR dashboard and SQL algorithm generated as part of the Collaborative should be made broadly available to general practices in the catchment to promote quality data collection.

Finding 48: Lessons from the Collaborative project can be used to support ongoing activities to embed quality improvement in general practice.

8.3.4 Barriers and enablers of sustainability

Enablers

Gippsland PHN is a central coordinating and commissioning agency that provides practice supports and systems integration. They have established and broad reaching networks and engagement with primary care providers across Gippsland, and routinely engage with stakeholders that are also key to the Initiative. Administration through Gippsland PHN was another strength of the Initiative implementation. This made it possible to leverage the existing networks and connections of the PHN, existing programs managed by the PHN (including HealthPathways) and PHN resources including staff. However, co-commissioning with the Department of Health to support brokerage of the necessary relationships with the local hospital networks and other state-funded services may have provided additional value.

The aims and goals of the Initiative were sensitive to and aligned with the pending primary healthcare reform as detailed in the Australian Government Primary Health Care 10 Year Plan 2022-2032.[26] Amongst other measures, the 10-year plan discusses quality improvement through data-driven insights, multidisciplinary team based care to support person-centred care, empowering people to stay healthy and manage their own health care and delivering regionally and locally integrated health service models through joint planning and collaborative commissioning at regional and state-wide levels. Alignment with goals of the 10-year plan was a strength of the Initiative. It provided increased opportunity for linkages with other project / programs, funding options and other supports.

For example, through the Initiative Gippsland PHN was able to commission education and training sessions from the Improvement Foundation for general practice on the PIP QI incentive, which was introduced in 2019. In addition, Gippsland PHN was able to provide additional training and supports for QI activities including data collection through the Collaborative project, and Screen for

[26] Future focused primary health care: Australia's Primary Health Care 10 Year Plan 2022-2032

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Me GP Grants. Through the Collaborative project, Gippsland PHN also commissioned development of a POLAR dashboard for outcome measures, which overlap with the QI measure of the PIP QI incentive. This work supports all general practices using POLAR to collect, submit and review data. At the time of analysis, the number of general practices using POLAR had increased from 13 to 16 in Latrobe (23% increase), and from 23 to 42 practices (83% increase) in other areas of Gippsland. As evidenced, the Initiative allowed Gippsland PHN to assist general practices establish QI processes which supported data collection and submission and is sustainable through PIP incentive payments.

In this vein, the use of automated medical software systems that deliver automated campaigns for lapsed screeners and software optimisation for opportunistic screening also enable sustainable processes for general practice in the region.

Finding 49: Two of the key strengths and enablers of the Initiative were the administration through Gippsland PHN, and the alignment with broader national primary healthcare reforms. In addition, creation of data dashboards, software optimisation and use of automated campaigns for lapsed screeners provide a foundation for future ongoing activity.

Barriers

To generate sustainable programs, it is important to understand the following attributes:

- the effectiveness of the program
- the cost of the program and if it offered value for money compared with the outcomes generated, and
- recurring costs and potential funding options.

While service provision / training programs sought to capture data on program effectiveness, there was limited information gathered on the effectiveness of social marketing and awareness raising campaigns such as Screen For Me and Pitch to Quit. Further information at the community level is required to understand the full impact of activities implemented under the Initiative and the resulting behaviour changed generated, if any. A catchment wide survey is one mechanism that could be used to capture this information on multiple activities from the Initiative. Other targeted measures could also be used for individual projects. For example, women could be asked 'What prompted you to get screened today?' when attending breast or cervical screening, or links to online surveys could be embedded in the Screen For Me cards to enable people to feedback the impact receiving a Screen For Me they had.

There was limited program cost information available for analysis, limiting the ability of the meta-evaluation to determine which projects represented value for money. A greater understanding of value for money of individual projects will enable Gippsland PHN and other stakeholders to prioritise activities and make informed decisions on which project to continue investment in.

Consideration of sustainable funding models was not embedded into the design of projects implemented under the Initiative. This limited the sustainability of activities as there was no plan for continued funding options to be rolled in. For example, how projects (if considered successful) could leverage existing funding sources such as the MBS and PBS (where appropriate) was not embedded into project evaluation or PCG discussions. Likewise, some alternative models of care such as nurse-led clinics do not have obvious funding streams to tap into. Consideration needs to be given to co-commissioning options to support such models if proven successful and value for money.

It is also important to understand the time required to generate behaviour change among a community, which will vary depending on the level of readiness for change of individual people. The LHIZ Initiative set about to create large scale social change over a five-year period, however it was significantly impacted by the COVID-19 pandemic. Although five years should be sufficient time to observe behaviour change impacts, this did not allow for time to co-design projects and new models of care with the community. For example, the LSSS was not developed until year four of the five-year Initiative, which only allowed for six-months of clinical service provision. This may not have been sufficient time to observe medium-term impacts from the program.

Establishing programs of activities is another mechanism that can support the effectiveness of projects and thus drive value for money. Notwithstanding the vast number and broad range of projects delivered under the Initiative, programs of

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activities within the Initiative were not developed outside of the cancer screening theme.

For example, consideration of a series of projects that could build on one another and leverage off one another was not apparent for the smoking cessation and opportunistic screening themes. Conversely, the cancer screening theme included a social marketing campaign (Screen For Me), which was included in the design of health system facing projects including the Collaborative quality improvement project and the Screen For Me GP Grants. These efforts were supported by other cancer screening projects to improve re-engagement of overdue screeners, and to improve access (e.g. the Churchill Neighbourhood Bust Trip and the training of nurses to undertake cervical screening). Collectively the cancer screening projects worked together to address awareness (and re-engagement), consistent messaging, accessibility and health system processes. In comparison, projects under the smoking cessation and opportunistic screening themes were more reactive and ad-hoc.

Finally, healthcare workforce turnover is another barrier in Latrobe, as it is in Gippsland and all Australian regional and rural settings Initiative supports such as education and training, general practice data support and HealthPathways need to be part of an ongoing program to mitigate the changing workforce. Therefore, it is essential that health professionals take up available training. Future uptake may be assisted by financial incentives to compensate loss of productivity to attend training.

Finding 50: The main barriers to sustainability for projects under the Initiative were a lack of demonstration of value for money and lack of sustainable funding models identified. This may be due to lack of clarity in project design and objectives. Health workforce turnover is another broad challenge that requires ongoing education / training initiatives to be maintained.

8.4 CONCLUSION

There are learnings / activities from individual projects that will be maintained beyond the Initiative. These include legacy media items from social marketing campaigns and data dashboards, software optimisation and use of automated campaigns for lapsed screeners.

However, limited data to determine if projects were value for money combined with lack of sustainable funding options hindered the establishment of new models of care in routine business practices.

Recommendation 15: In future, consideration to sustainable funding models needs to be embedded into new models of care to ensure sustainability if proven successful.

Quality improvement processes appear to be improving through the introduction of the PIP QI incentive and resources available through the Initiative supported the uptake of this by general practice. Embedding quality improvement process takes time and with high workforce fatigue and turnover needs ongoing support and resources for health professionals to implement.

Recommendation 16: Continue to provide ongoing support to general practice regarding quality improvement processes.

9 DISCUSSION

The Hazelwood Mine fire in 2014 brought the health of the Latrobe Valley into the spotlight. The inquiry into the fire included recommendations to investigate health consequences resulting from the fire such as increased cardiovascular disease and cancer diagnosis.[27] However, it also sparked preventative public health interest and led to the development of the LHIZ Initiative.

In considering population health and social determinants of health, it is important to understand that people in Latrobe are more likely to:

- experience high disadvantage compared to the Australian population (28% compared to 10%, respectively)
- be aged 65 years or more compared to the Victorian population (21.1% compared to 16.8%, respectively)
- smoke (22% of adults in Latrobe are current smokers compared to 16% for Victoria)
- consume alcohol at levels likely to increase risk of lifetime harm (64% of adults in Latrobe compared to 60% in Victoria)
- experience an avoidable death from chronic disease:
  - avoidable deaths due to heart related issues: 65.5 per 100,000 population in Latrobe compared to 32.4 per 100,000 in Victoria
  - avoidable deaths due to cancer: 52.7 per 100,000 in Latrobe compared to 28.2 per 100,000 in Victoria
  - avoidable deaths due to Chronic Obstructive Pulmonary Disease: 28.1 per 100,000 in Latrobe compared to 8.3 in Victoria
  - avoidable deaths due to diabetes: 12.0 per 100,000 in Latrobe compared to 5.1 in Victoria.[28]

Before health improvements can be achieved, it is necessary to understand the challenges faced by the community and the barriers to making behavioural changes to improve health at both the population level and the health system level. Through a process of co-design with the community the LHIZ Initiative aimed to find innovative strategies that would overcome obstacles to changing health behaviours, as well as introduction system level change to support this.

There were many learnings from the Initiative and activities showed promising results around community engagement and addressing identified barriers. Likewise, system level approaches to support quality improvement in general practice were observed. For example, the work of the Collaborative showed promising results which bucked the trends of the broader cervical and bowel screening results. However, the Collaborative was a resource intensive project that required time commitments from general practice staff, workshop facilitators, educators and project managers. Finding opportunities to replicate the enablers of this project (such as low-cost ideas developed by each practice that were tailored for their clientele or specific patient populations and driven by data) in a more sustainable, less resource intensive way for both funder and implementers, has potential to drive meaningful change.

A downfall of the Initiative was the overall lack of integration between health professionals. Future programs need to engage more collaboration and integration among health professionals to develop system-wide changes. This requires shared language, shared goals, shared data / indicators and shared knowledge through training or improvement activities. For this to be successful, health professionals need to be involved in the co-design of programs including education / training packages to ensure uptake, and local stakeholders and services providers need to be engaged with, and supportive of, the activities undertaken.

Looking at the impacts of the Initiative, there were insufficient data available to determine the full effects and impacts at the time of this report. Evaluation capability needs to continue to be strengthened at local level, including community participation in monitoring and evaluation processes. It is also important to

[27] Inspector-General for Emergency Management: Hazelwood Mine Fire Inquiry, Progress Report 2021

[28] Gippsland PHN Health Needs: Latrobe Local Government Area snapshot 2022

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acknowledge the time and resources required to drive behaviour change among community members and among health professionals.

The impact of the COVID-19 pandemic on the community and health system priorities must also be taken into consideration when assessing the expectations from the LHIZ Initiative. The health system was overwhelmed by the pandemic resulting in high levels of workforce fatigue. Access to services such as screening was limited for periods of time due to lockdowns. People may have avoided face to face services for fear of contracting the virus. Initiative outcomes were significantly impacted by the pandemic. Interpretation of findings in this report must be done in light of the pandemic and its consequences.

The Initiative demonstrated some promising results for cancer screening, with an increase in the proportion of the population presenting for cervical smear screening in general practice over the last three years. However, with breast and bowel cancer screening rates remaining consistently on par with (and slightly higher than) Victorian screening rates, further work should be prioritised on population cohorts that have been identified with low screening rates such as specific geographical locations, men of certain age groups, Aboriginal and Torres Strait Islander people, culturally and linguistically diverse population group or LGBTIQ+ individuals.

Although smoking rates among people from Latrobe did not decrease over the time of the Initiative, there was a suggestion that people were decreasing the number of cigarettes smoked, evidenced by a decrease in daily smokers. Similarly, the preliminary results from the Latrobe Smoking Support Service showed a reduction in smoking among 57% of participants with a further 18% quitting (i.e. a total of 75% of participants reducing cigarette intake). Understanding the time required for behaviour change among smokers will help establish realistic timeframes for future projects. Follow up of participants to ascertain if the behaviour changes have been maintained or improved will be informative for future design. Future work will also need to embed strategies to target the increasing uptake of vaping, especially among young adults.

Availability of pre-existing intervention products for both smoking cessation and cancer screening resulted in these themes being prioritised – both in timing and number of activities – over risk and opportunistic screening. Despite the early implementation of the *Health Check Risk Assessment Tool for Chronic Disease Pilot* (which was not effective), remaining projects did not commence until 2021 (Student Led Pop-Up Health Check Clinics and General Practice Outreach Health Checks) with mixed results and limited system integration. High levels of chronic disease and avoidable deaths related to chronic disease in the Latrobe community demonstrate the need for projects in this area. Moving forward, a higher priority needs to be given to raising awareness of risk among individuals and promotion of opportunistic screening among health professionals.

Table 9.1 provides a brief assessment if the Initiative against the nine deliverables from the Hazelwood Mine Fire Inquiry (Deliverables 69–77).

Table 9.1: Assessment of the LHIZ Initiative against the project objectives

PROJECT OBJECTIVES	ASSESSMENT OF ACHIEVEMENT (LHIZ INITIATIVE)
SMOKING CESSATION	
Co-develop a plan, with the community or community representatives, to engage other groups and sectors to increase quitting and decrease smoking uptake.	Partially achieved. Community consultation and co-design were undertaken. Themes addressed were raising awareness (Pitch to Quit), increasing access (Pharmacy Smoking Cessation Project) and increasing health professional engagement (Latrobe Smoking Support Service. Activities undertaken did not generate system-wide integration among health professionals, i.e. limited referrals from general practice to the Latrobe Smoking Support Service, reduced referrals to Quitline when training programs not provided.
Increase community knowledge of smoking risk and services that support quitting in Latrobe.	Partially achieved. Increased referrals from health professionals to Quitline corresponded to times when health professional education / training on smoking cessation was undertaken but

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PROJECT OBJECTIVES	ASSESSMENT OF ACHIEVEMENT (LHIZ INITIATIVE)
	waned during periods with no corresponding education / training.
(3) Increase the provision of best practice and evidence-based care to the community by: (a) Increasing health professionals' skills, confidence and knowledge in smoking cessation through engagement, education and quality improvement activities. (b) Redesigning clinical practice and environments in general practices, hospitals, dental practices, community health services and other primary care clinics. (c) Increasing community and social service professionals' skills, confidence and knowledge in providing smoking cessation advice through engagement and education. (d) Redesigning environments and screening practices in community and social service organisations.	Mostly achieved. Health professional education about brief interventions was provided. There was an increased awareness of Quitline and NRT among health professionals and individuals based on Quitline referral data. However, a system-wide approach was not implemented, and outcomes were not maintained. Future projects need to allow sufficient time for processes to be embedded as routine practice to ensure ongoing sustainability. The high turnover of healthcare workers in Latrobe requires the availability of ongoing / rolling training campaigns to ensure access for new health professionals.
Improve patient screening and data recording practices in general practice, hospitals, community health services and other primary care to evaluate the short and long-term impacts of systems changes, particularly among priority population groups.	Partially achieved. A smoking cessation initiative was implemented, with the aim to increase GP and other health professional referrals to support the population, although engagement from the Latrobe Health Assembly was limited to PCG engagement.
POPULATION BASED CANCER SCREENING	
Identify gaps in population-based bowel, breast and cervical cancer screening practice (processes, systems, referral pathways, follow up care and support) among health professionals including general practitioners and practice staff	Achieved. The Initiative undertook a comprehensive needs assessment upon commencement, much of which formed baseline data.
Establish a local governance model supporting population-based cancer screening programs in Latrobe.	Achieved. Community consultation and co-design were undertaken. However, there were insufficient data to demonstrate they resulted in beneficial patient outcomes or improved system processes in the longer-term.
Implement system improvements for follow up on positive results and timely access to local specialists and interventional services.	Mostly achieved. HealthPathways was utilised for specialist referrals.
Improve sustainable population-based bowel, breast and cervical cancer screening practice (processes, systems, referral pathways, follow up care and support) among health professionals including general practitioners and practice staff.	Partially achieved. There was low completion of quality improvement activities among general practice. New models of care were not established with sustainable funding models.

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PROJECT OBJECTIVES	ASSESSMENT OF ACHIEVEMENT (LHIZ INITIATIVE)
Increase whole of community awareness of population-based bowel, breast and cervical screening programs	Partially achieved. There is limited information gathered on the effectiveness of awareness.
Increase breast cancer screening rates for eligible Aboriginal and Torres Strait Islander women and women who speak a language other English at home to the state average.	Partially achieved. Cancer screening activities targeted geographic locations with low screening rates and undertook activities to engage Aboriginal and Torres Strait Islander people. Limited work was undertaken with other vulnerable population groups.
Increase breast cancer screening rates for women aged 50 -74 years living in Churchill, Moe and Morwell to the state average.	Partially achieved. The Initiative did not significantly affect breast screening rates. Additional data are required to assess the full impact of Initiative activities.
Increase bowel cancer screening rates for men aged 50 living in Latrobe to the state average.	Partially achieved. The Initiative did not significantly affect bowel screening rates. Additional data are required to assess the full impact of activities.
RISK ASSESSMENT AND OPPORTUNISTIC SCREENING	
Implement the Integrated Risk Assessment Tool (The Health Check).	Partially achieved. The Health Check Risk Assessment Tool for Chronic Disease pilot was undertaken, but the level of health system-integration offered through this project was limited.
Undertake a whole of system analysis for risk assessment and opportunistic screening and support services in Latrobe.	Achieved. Projects supported general practice to analyse system data and implementation of systems. A survey reported positive uptake of opportunistic screening.
Improve the provision of evidence based health assessment and screening care to the community.	Achieved. Improved health assessment and screening care were achieved through education and training for health professionals and practiced in pop up clinics and screening activities.

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APPENDIX A LHIZ PROJECT DOCUMENTS REVIEWED

Australian Primary Health Care Nurses Association: Supporting Establishment of Nurse Led Clinics for Risk Prevention Project Final Report, 2022

BreastScreen Victoria: Co-Branded GP Letter Trial Final Report 2021

BreastScreen Victoria: Gippsland Strategy Hazelwood Project Evaluation 2017

BreastScreen Victoria: Improving breast screening participation within Gippsland PHN Final Report 2020

Cancer Council Victoria: Bowel Comedy – Morwell, 2019 (email)

Churchill Neighbourhood Centre: Churchill BreastScreen Group Booking – Feedback report

Collaborative Evaluation & Research Group: Latrobe Smoking Support Service Evaluation 2022

Collaborative Evaluation & Research Group: Pharmacy Smoking Cessation Project Evaluation Report, 2022

Collaborative Evaluation & Research Group: Pitch To Quit Competition Evaluation

Collaborative Evaluation & Research Group: Pop Up Health Checks Evaluation Report 2022

Collaborative Evaluation & Research Group: Screen For Me Project Report and Evaluation, 2022

Federation University: Cervical Screen Survey Results, 2018

Gippsland PHN and Family Planning Victoria: Cervical Screening Test (CST) Training Course(s) Evaluation Report- November 2019 & October 2021

Gippsland PHN: Cancer Screening Collaborative Project Final Report

Gippsland PHN: Department of Health and Human Services IGEM Effectiveness Monitoring: Action 77 Embed the smoking cessation initiative, in partnership with key service providers.

Gippsland PHN: GP Outreach Health Checks, 2022

Gippsland PHN: HealthPathways – population-based cancer screening

Gippsland PHN: HealthPathways – risk assessment and opportunistic screening

Gippsland PHN: HealthPathways – smoking cessation

Gippsland PHN: Latrobe Community Cancer Screening Grants

Gippsland PHN: Latrobe Health Innovation Zone: Early Detection and Screening including Tobacco Screening & Identifying Chronic Disease Training – Benchmarque Training

Gippsland PHN: LHIZ Acquittal data from January 2017 to December 2021

Gippsland PHN: LHIZ Mid-Term Reports (six-monthly) form January 2017 to December 2021

Gippsland PHN: National Bowel Cancer Screening Program (NBCSP) Bowel Test Kit distribution trial within LHIZ - Briefing Paper, January 2020

Gippsland PHN: Nurse Cervical Screening Training Project, Post Training Report

Gippsland PHN: Private Bowel Cancer Screening Test Kit distribution within LHIZ - Briefing Paper, February 2020

Gippsland PHN: Screen For Me – Engaging General Practice Final Report

Gippsland PHN: Smokefree Gippsland Evaluation Report, 2020

Gippsland PHN: Smoking Status of Women Delivering Babies: Scoping work in collaboration with Safer Care Victoria & Quit Victoria Briefing Paper

Health and Community Consulting Group: Evaluation of the Pilot of the Integrated Risk Assessment Tool for Chronic Disease: Final Report, 2018

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Health Issues Centre Activity Report: Consumer conversations about beliefs and attitudes to population-based cancer screening in Latrobe, Gippsland. Stage 1 – Vox Pops (Traralgon, Churchill, Moe, Morwell), 2018

Improvement Foundation workshops on PIP QI: evaluation reports

Improvement Foundation: Innovation Workshop Report, Results from the Smoke-Free Latrobe Innovation Workshops

La Trobe University: Social Network Analysis Final Report 2020

Larter Consulting: Community consultation on opportunistic screening for risk factors for chronic disease Final report, August 2021

Larter Consulting: Listening to Latrobe: Towards improved health outcomes for people living with chronic disease, September 2020

Larter Consulting: Summary report of PCG consultation themes, 2019

Larter Consulting: Training of Latrobe general practices to utilise MBS billing opportunities to improve opportunistic screening for chronic conditions, 2022

Latrobe GP survey results 2019

Latrobe Health Assembly: Bowel Cancer Screening Focus Group 2017

Latrobe Health Assembly: Breast Cancer Screening Focus Group 2017

Men's Shed Bowel Cancer Screening Survey Results, 2018

MMReserach: Gippsland Primary Health Network and Latrobe Community Health Service smoking clinic community consultations report of qualitative research 2020

MMReserach: Gippsland Primary Health Network Cancer Screening Research Report of qualitative research, 2019

MMReserach: Gippsland Primary Health Network research with Latrobe Valley smokers report of qualitative research 2019

Pitch to Quit Project Review

Ramahyuck Cancer Screening Initiatives – Women's pamper day, 2019

Screen For Me – Nanoo Nanoo Debrief 2019

Semantic Consulting: LHIZ Digital Health Strategy 2019

APPENDIX B EVALUATION RUBRIC

Table A: Local data sources - GP data (POLAR, CMS, Questionnaire) Quitline referrals, Life! Referrals

Criteria	Standard								
	Very poor	Poor	Fair	Acceptable	Good	Very good	Excellent	Baseline data and source	Document reference
Smoking									
DB Indicator 1.1 Quitline referrals by health professionals	Decrease from baseline	No change from baseline	1-12.5% increase from baseline	13-24.5% increase from baseline	25-37.5% increase from baseline	38-49.5% increase from baseline	50% and above increase from baseline	Latrobe and Baw Baw 67 (2016) Gippsland 81 (Quit Victoria)	DOC/18/5349 DOC/19/2227 DOC/20/1622
DB Indicator 1.2 Quitline callers using NRT	Decrease from baseline	No change from baseline	1-12.5% increase from baseline	13-24.5% increase from baseline	25-37.5% increase from baseline	38-49.5% increase from baseline	50% and above increase from baseline	Latrobe and Baw Baw 13 (2016) Gippsland 19 (Quit Victoria)	DOC/19/589 DOC/19/2227 DOC/20/1622
DB Indicator 1.3, 1.3.1A Smoking status – Smoker, 10-85+ years	Increase from baseline	No change from baseline	1-1.9% decrease from baseline	2-2.9% decrease from baseline	3-3.9% decrease from baseline	4-4.9% decrease from baseline	5% and above decrease from baseline	Latrobe practices 23.9% Gippsland practices 16.7% Victoria TBC (POLAR GP data, 2017-18) CMS - TBD	DOC/18/12604 DOC/20/1622
DB Indicator 1.3 Smoking status - Ex-smoker, 10- 85+ years	Decrease from baseline	No change from baseline	1-1.9% increase from baseline	2-2.9% increase from baseline	3-3.9% increase from baseline	4-4.9% increase from baseline	5% and above increase from baseline	Latrobe practices 22.9% Gippsland practices 26.9% Victoria TBC (POLAR GP data, 2017-18) CMS - TBD	DOC/18/12604 DOC/20/1622

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Criteria	Standard							Baseline data and source	Document reference
	Very poor	Poor	Fair	Acceptable	Good	Very good	Excellent		
Indicator 1.3 Smoking status - Unknown, 10-85+ years	Increase from baseline	No change from baseline	1-3.75% decrease from baseline	3.8-7.5% decrease from baseline	7.6-11.25% decrease from baseline	11.3-14.9% decrease from baseline	15% and above decrease from baseline	Latrobe practices 20.7% Gippsland practices 20.9% Victoria TBC (POLAR GP data, 2017-18) CMS - TBD	DOC/18/12604 DOC/20/1622
NRT, varenicline or bupropion prescriptions, 10-85+ years	Decrease from baseline	No change from baseline	1-3.75% increase from baseline	3.8-7.5% increase from baseline	7.6-11.25% increase from baseline	11.3-14.9% increase from baseline	15% and above increase from baseline	Latrobe practices 678 Gippsland practices 1030 Victoria TBC (POLAR GP data, Sept 2017-Mar 2018) CMS - TBD	DOC/19/6137 DOC/20/1622
Cancer screening									
GP follow up/ reminder/ prompt for breast cancer screening	Increase in % of GPs responding 'Routinely' to using a patient prompt and/or reminder system for asymptomatic patients who are due for their breast cancer screens							Latrobe GP screening interviews (2019)	DOC/18/9206 DOC/20/1622
GP follow up/ reminder/ prompt for cervical cancer screening	Increase in % of GPs responding 'Routinely' to using a patient prompt and/or reminder system for asymptomatic patients who are due for their cervical cancer screens							Latrobe GP screening interviews (2019)	DOC/18/9206 DOC/20/1622
GP follow up/ reminder/ prompt for bowel cancer screening	Increase in % of GPs responding 'Routinely' to using a patient prompt and/or reminder system for asymptomatic patients who are due for their bowel cancer screens							Latrobe GP screening interviews (2019)	DOC/18/9206 DOC/20/1622
Opportunistic screening markers									
GP screening for smoking	Increase in % of GPs responding 'Routinely' to using a 3-step Brief Intervention Ask Advice Help model							Latrobe GP screening interviews (2019)	DOC/18/9206 DOC/20/1622

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Criteria	Standard							Baseline data and source	Document reference
	Very poor	Poor	Fair	Acceptable	Good	Very good	Excellent		
Weight management DB Indicator 3.1 Body Mass Index (BMI) status – Unknown, 15-85+ years	Increase from baseline	No change from baseline	1-4.9% decrease from baseline	5-9.9% decrease from baseline	10-14.9% decrease from baseline	15-19.9% decrease from baseline	20% and above decrease from baseline	Latrobe practices 48.3% Gippsland practices 46.8% Victoria TBC (POLAR GP data, 2017-18) CMS - TBC	DOC/18/12604 DOC/20/1622
DB Indicator 3.2 Waist Circumference status – Unknown, 15-85+ years	Increase from baseline	No change from baseline	1-9.9% decrease from baseline	10-19.9% decrease from baseline	20-29.9% decrease from baseline	30-39.9% decrease from baseline	40% and above decrease from baseline	Latrobe practices 75.5% Gippsland practices 83.6% Victoria TBC (POLAR GP data, 2017-18) CMS - TBD	DOC/18/12604 DOC/20/1622
GP screening for weight management	Increase in % of GPs responding 'Routinely' to screening for BMI and waist circumference							Latrobe GP screening interviews (2019)	DOC/18/9206 DOC/20/1622
GP screening for healthy eating	Increase in % of GPs responding 'Routinely' to screening patients for healthy eating							Latrobe GP screening interviews (2019)	DOC/18/9206 DOC/20/1622
GP screening for physical activity	Increase in % of GPs responding 'Routinely' to screening patients for physical activity							Latrobe GP screening interviews (2019)	DOC/18/9206 DOC/20/1622
DB Indicator 3.3 Alcohol consumption status – Unknown, 15-85+ years	Increase from baseline	No change from baseline	1-4.9% decrease from baseline	5-9.9% decrease from baseline	10-14.9% decrease from baseline	15-19.9% decrease from baseline	20% and above decrease from baseline	Latrobe practices 51.0% Gippsland practices 33.9% Victoria TBC (POLAR GP data, 2017-18) CMS - TBD	DOC/18/12604 DOC/20/1622

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Criteria	Standard							Baseline data and source	Document reference
	Very poor	Poor	Fair	Acceptable	Good	Very good	Excellent		
GP screening for alcohol consumption	Increase in % of GPs responding 'Routinely' to screening patients for risky drinking							Latrobe GP screening interviews (2019)	DOC/18/9206 DOC/20/1622
DB Indicator 3.4 Systolic blood pressure status – Unknown, 15-85+ years	Increase from baseline	No change from baseline	1-2.4% decrease from baseline	2.5-4.9% decrease from baseline	5-7.4% decrease from baseline	7.5-9.9% decrease from baseline	10% and above decrease from baseline	Latrobe practices 19.7% Gippsland practices 17.9% Victoria TBC (POLAR GP data, 2017-18) CMS - TBD	DOC/18/12604 DOC/20/1622
GP screening for blood pressure	Increase in % of GPs responding 'Routinely' to screening patients for blood pressure							Latrobe GP screening interviews (2019)	DOC/18/9206 DOC/20/1622
DB Indicator 3.5 Absolute CVD risk status – Unknown, 15-85	TBD	TBD	TBD	TBD	TBD	TBD	TBD	Latrobe practices Gippsland practices Victoria TBC (POLAR GP data, 2017-18) CMS - TBD	
GP screening for absolute CVD risk	Increase in % of GPs responding 'Routinely' to screening patients for absolute CVD risk							Latrobe GP screening interviews (2019)	DOC/18/9206 DOC/20/1622
DB Indicator 3.6 Cholesterol status – Unknown, 15-85+ years	Increase from baseline	No change from baseline	1-4.9% decrease from baseline	5-9.9% decrease from baseline	10-14.9% decrease from baseline	15-19.9% decrease from baseline	20% and above decrease from baseline	Latrobe practices 53.7% Gippsland practices 43.4% Victoria TBC (POLAR GP data, 2017-18) CMS - TBD	DOC/18/12604 DOC/20/1622
GP screening for cholesterol	Increase in % of GPs responding 'Routinely' to screening patients for cholesterol							Latrobe GP screening interviews (2019)	DOC/18/9206 DOC/20/1622

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Criteria	Standard							Baseline data and source	Document reference
	Very poor	Poor	Fair	Acceptable	Good	Very good	Excellent		
Type 2 diabetes DB Indicator 3.7 At risk of diabetes, 15-85+ years - unknown (HBA1C pathology tests)	TBD	TBD	TBD	TBD	TBD	TBD	TBD	Latrobe practices Gippsland practices Victoria TBC (POLAR GP data, 2017-18) CMS - TBD	DOC/18/12604 DOC/20/1622
GP screening for Type 2 diabetes	Increase in % of GPs responding 'Routinely' to screening patients for type 2 diabetes							Latrobe GP screening interviews (2019)	DOC/18/9206 DOC/20/1622
***Life!* referrals – Self-referrals**	Decrease from baseline	No change from baseline	1-12.5% increase from baseline	13-24.5% increase from baseline	25-37.5% increase from baseline	38-49.5% increase from baseline	50% and above increase from baseline	Latrobe referrals 15 (Diabetes Victoria, 1 July 2016 - 30 Sept 2017)	DOC/19/591 DOC/20/1622
***Life!* referrals – GP-referrals**	Decrease from baseline	No change from baseline	1-12.5% increase from baseline	13-24.5% increase from baseline	25-37.5% increase from baseline	38-49.5% increase from baseline	50% and above increase from baseline	Latrobe referrals 57 (Diabetes Victoria, 1 July 2016 - 30 Sept 2017)	DOC/19/591 DOC/20/1622
***Life!* referrals – Other Referrals (Health professionals, Facilitator/Provider)**	Decrease from baseline	No change from baseline	1-12.5% increase from baseline	13-24.5% increase from baseline	25-37.5% increase from baseline	38-49.5% increase from baseline	50% and above increase from baseline	Latrobe referrals 36 (Diabetes Victoria, 1 July 2016 - 30 Sept 2017)	DOC/19/591 DOC/20/1622

Notes: DB = Dashboard; CVD = Cardiovascular disease; NRT = Nicotine replacement therapy
Percentage standard categories are absolute percentage changes from baseline percentages.
POLAR data for Gippsland practices includes data for Latrobe's five neighbouring LGAs (Bass Coast, Baw Baw, East Gippsland, South Gippsland and Wellington)

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Table B: Population health data – BreastScreen Victoria, Victorian Cytology Service (National Cancer Screening Program, National Bowel Cancer Screening Program)

Criteria	Standard								
	Very poor	Poor	Fair	Acceptable	Good	Very good	Excellent	Baseline data and source	Document reference
Cancer screening									
DB Indicator 2.1 Breast cancer screening participation rates, women aged 50-74 living in Latrobe	Decrease from baseline	No change from baseline	1-1.9% increase from baseline	2-2.9% increase from baseline	3-3.9% increase from baseline	4-4.9% increase from baseline	5% and above increase from baseline	Latrobe 52.6% Gippsland 54.0% Victoria 52.3% (BSV, 2013-15) Update with 2015-17 data when available	DOC/17/4679 DOC/20/1627 DOC/20/1618 DOC/19/19741
DB Indicator 2.1 Breast cancer screening participation rates, women aged 50-74 living in Moe	Decrease from baseline	No change from baseline	1-1.9% increase from baseline	2-2.9% increase from baseline	3-3.9% increase from baseline	4-4.9% increase from baseline	5% and above increase from baseline	Moe 49.9% Gippsland 54.0% Victoria 52.3% (BSV, 2013-15) Update with 2015-17 data when available	DOC/17/4679 DOC/20/1627 DOC/20/1618
DB Indicator 2.1 Breast cancer screening participation rates, women aged 50-74 living in Morwell	Decrease from baseline	No change from baseline	1-1.9% increase from baseline	2-2.9% increase from baseline	3-3.9% increase from baseline	4-4.9% increase from baseline	5% and above increase from baseline	Morwell 50.1% Gippsland 54.0% Victoria 52.3% (BSV, 2013-15) Update with 2015-17 data when available	DOC/17/4679 DOC/20/1627 DOC/20/1618
DB Indicator 2.1 Breast cancer screening participation rates, women aged 50-74 living in Churchill	Decrease from baseline	No change from baseline	1-1.9% increase from baseline	2-2.9% increase from baseline	3-3.9% increase from baseline	4-4.9% increase from baseline	5% and above increase from baseline	Churchill 47.5% Gippsland 54.0% Victoria 52.3% (BSV, 2013-15) Update with 2015-17 data when available	DOC/17/4679 DOC/20/1627 DOC/20/1618
DB Indicator 2.1 Breast cancer screening participation rates, ATSI women aged 50-74 living in Latrobe	Decrease from baseline	No change from baseline	1-1.9% increase from baseline	2-2.9% increase from baseline	3-3.9% increase from baseline	4-4.9% increase from baseline	5% and above increase from baseline	Latrobe 38.5% Gippsland 51.1% Victoria 42% (BSV, 2013-15) Update with 2015-17 data when available	DOC/17/4679 DOC/20/1627 DOC/20/1618

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Criteria	Standard								
	Very poor	Poor	Fair	Acceptable	Good	Very good	Excellent	Baseline data and source	Document reference
DB Indicator 2.1 Breast cancer screening participation rates, CALD women aged 50-74 living in Latrobe	Decrease from baseline	No change from baseline	1-1.9% increase from baseline	2-2.9% increase from baseline	3-3.9% increase from baseline	4-4.9% increase from baseline	5% and above increase from baseline	Latrobe 43.3% Gippsland 46.7% Victoria 53.7% (BSV, 2013-15) Update with 2015-17 data when available	DOC/17/4679 DOC/20/1627 DOC/20/1618
DB Indicator 2.3 Bowel cancer screening participation rates, men aged 50-74 living in Latrobe	Decrease from baseline	No change from baseline	1-1.9% increase from baseline	2-2.9% increase from baseline	3-3.9% increase from baseline	4-4.9% increase from baseline	5% and above increase from baseline	Latrobe 43.5% Gippsland 47.3% Victoria 40.5% (NBCSP, 2016-17)	DOC/19/1842 DOC/20/1627
DB Indicator 2.3 Bowel cancer screening participation rates, men aged 50-59 living in Latrobe	Decrease from baseline	No change from baseline	1-1.9% increase from baseline	2-2.9% increase from baseline	3-3.9% increase from baseline	4-4.9% increase from baseline	5% and above increase from baseline	Latrobe 32.8% Gippsland 37.0% Victoria 33.0% (NBCSP, 2016-17)	DOC/19/1842 DOC/20/1627
DB Indicator 2.3 Bowel cancer screening participation rates, men aged 50-59 living in Morwell	Decrease from baseline	No change from baseline	1-1.9% increase from baseline	2-2.9% increase from baseline	3-3.9% increase from baseline	4-4.9% increase from baseline	5% and above increase from baseline	Morwell 26.1% Gippsland 37.0% Victoria 33.0% (NBCSP, 2016-17)	DOC/19/1834 DOC/20/1627
DB Indicator 2.2, 2.2.1 Cervical cancer screening participation rates (GP- and self-collected), women aged 25-74 living in Latrobe	Decrease from baseline	No change from baseline	1-1.9% increase from baseline	2-2.9% increase from baseline	3-3.9% increase from baseline	4-4.9% increase from baseline	5% and above increase from baseline	Latrobe 54.4% (20-69 years) Gippsland 58.1% Victoria 57.0% (20-69 years Crude rate) (NCSP, 2015-16)	Latrobe, Gippsland data DOC/18/13624 Vic data DOC/18/13634 DOC/20/1627
DB Indicator 2.2, 2.2.2 Cervical cancer screening participation rates (GP-collected), women aged 25-74 living in Latrobe	TBD	TBD	TBD	TBD	TBD	TBD	TBD	NCSP, 2018-19	DOC/20/1627

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Criteria	Standard								
	Very poor	Poor	Fair	Acceptable	Good	Very good	Excellent	Baseline data and source	Document reference
DB Indicator 2.2, 2.2.3 Cervical cancer screening participation rates (self-collected), women aged 25-74 living in Latrobe	TBD	TBD	TBD	TBD	TBD	TBD	TBD	NCSP, 2018-19	DOC/20/1627

Notes: DB = Dashboard; BSV = BreastScreen Victoria; NCSP = National Cancer Screening Program; NBCSP = National Bowel Cancer Screening Program; CALD = Culturally and Linguistically Diverse; ATSI = Aboriginal and Torres Strait Islander

Percentage standard categories are absolute percentage changes from baseline percentages.

POLAR data for Gippsland practices includes data for Latrobe's five neighbouring LGAs (Bass Coast, Baw Baw, East Gippsland, South Gippsland and Wellington)

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APPENDIX C PLANNED VERSUS AVAILABLE DATA

Type of data	Planned	Available
Health system facing	Consultation with or survey of PCG members Frequency: mid-point and completion	Mid-point only
Community facing	• Key informant interviews • Computer Assisted Telephone Interviews (CATI) • Focus groups utilising existing community groups • Workplace surveys • Paper-based surveys in waiting rooms • Ad-hoc pop-ups, and • Social media analytics.	Limited social media analytics Remaining activities did not occur
GP survey	Interviews or online survey Frequency: mid-point and completion	Mid-point only
GP data	• POLAR data extracts, and • Manual data extracts from general practices not using POLAR Frequency: 6 monthly	POLAR data only
Hospital data	Colonoscopy and colposcopy data including wait times	n/a
External data	• Quit Victoria: referrals to Quitline - every 12 months • BreastScreen Victoria: (i) screening volumes, (ii) wait times (booking to screening; screening to assessment) – every 12 months • Victorian Cytology Service: (i) cervical screening and (ii) bowel screening - every 12 months • Life! Program: referrals to program - every 12 months	• Quit Victoria: referrals to Quitline - every 12 months • BreastScreen Victoria (screening participation rates only) – every 12 months • Victorian Cytology Service: n/a • Life! Program: referrals to program - every 12 months