21-year partnership – has it made a difference?

Evaluating the Fairfield Health Partnership

Dissertation

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15624 Research in Local Government: Context B

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If you understood everything I said, you'd be me."~ Miles Davis

Chapter 1

Introduction and Background

BACKGROUND

Fairfield City Council (FCC) has been working with a formal partnership arrangement with NSW Health since 1995, providing a unique opportunity to evaluate the effectiveness of health partnerships (HP) over two decades. This research evaluates the Fairfield Health Partnership (FHP) using a two-pronged approach which measures both the effectiveness of the partnership (process) as well as the influence it has had on the health related risk behaviours (impact). The ex post facto research uses both qualitative and quantitative to examine if the working together achieved better outcomes?

The concept of HPs has been established on the foundation that no single organisation has control over all the determinants of health (Schoen et al 2014). Partnerships to improve health were first identified in the 1986 Ottawa Charter for Health Promotion with the Jakarta Declaration (WHO 1997) and Bangkok Charter (WHO 2005) bolstering partnerships as an essential instrument to improving health of populations.

Concept of partnerships has grown in popularity, as an avenue for addressing complex or 'wicked problems' which single organisations have been unable to tackle (Rittel and Weber 1973). Partnerships are considered necessary and advantageous for addressing society's challenges (Bryson *et al* 2006) which requires managers and workers to think differently, beyond disciplines and sector boundaries, moving away from silos (Norris-Tirrell and Clay 2010). Leung, 2012 identified that cross-sector partnerships enables 'collaborative advantage' whereby organisations working together generate something greater than the sum of their parts. However, despite HPs being applied for more than three decades, the evidence to support partnerships as a way of improving health is absent (Hayes et al 2012; Dowling et al 2004) due to the difficulties in not only measuring health impacts but also in attributing any change to the partnership (Hayes et al 2012).

Partnerships ideology continues to be 'on trend' with recent government programs being founded on the principle that in order to effect broader changes to the population's health, there needs to be collaboration of organisations other than those traditionally responsible for health, as evidenced through Health Public Policy, Health for All and Health Community Initiatives (Leung 2012). Local government (LG) is continuing to evolve as a key partner in improving health (Corne et al 1999; Rantala et al 2014: 93).

Recent changes to the *Local Government Act 1993* further reinforces the role of LG in creating healthy communities but also emphasises the need to work co-operatively with other levels of government. The amended Local Government Amendment (Governance and Planning) Bill 2016 *states* the role of councils as:

> *The object of the principles for councils …. is to provide guidance to enable councils to carry out their functions in a way that facilitates local communities that are strong, healthy and prosperous.*
>
> *Clause 8.1.e Guiding Principles purports Councils should work co-operatively[1] with other councils and State Government to achieve desired outcomes for the local community ….(inter alia).*

The evaluation of the FHP is essential to building the foundations on which LG can embrace its evolving role in health promotion and established the principles for collaborative partnerships, through fulfilling a gap in the research. The research concludes with the development of an evidence-based Partnership Capability Framework (PCF) to inform LG sector policy and practice, beyond the health paradigm.

[1] The Oxford Dictionary defines co-operatively as "*a way that involves mutual assistance in working towards a common goal: Jointly by a group of people, with profits or benefits shared among them."*

FOUNDATIONS OF HEALTH AND HEALTH PARTNERSHIPS

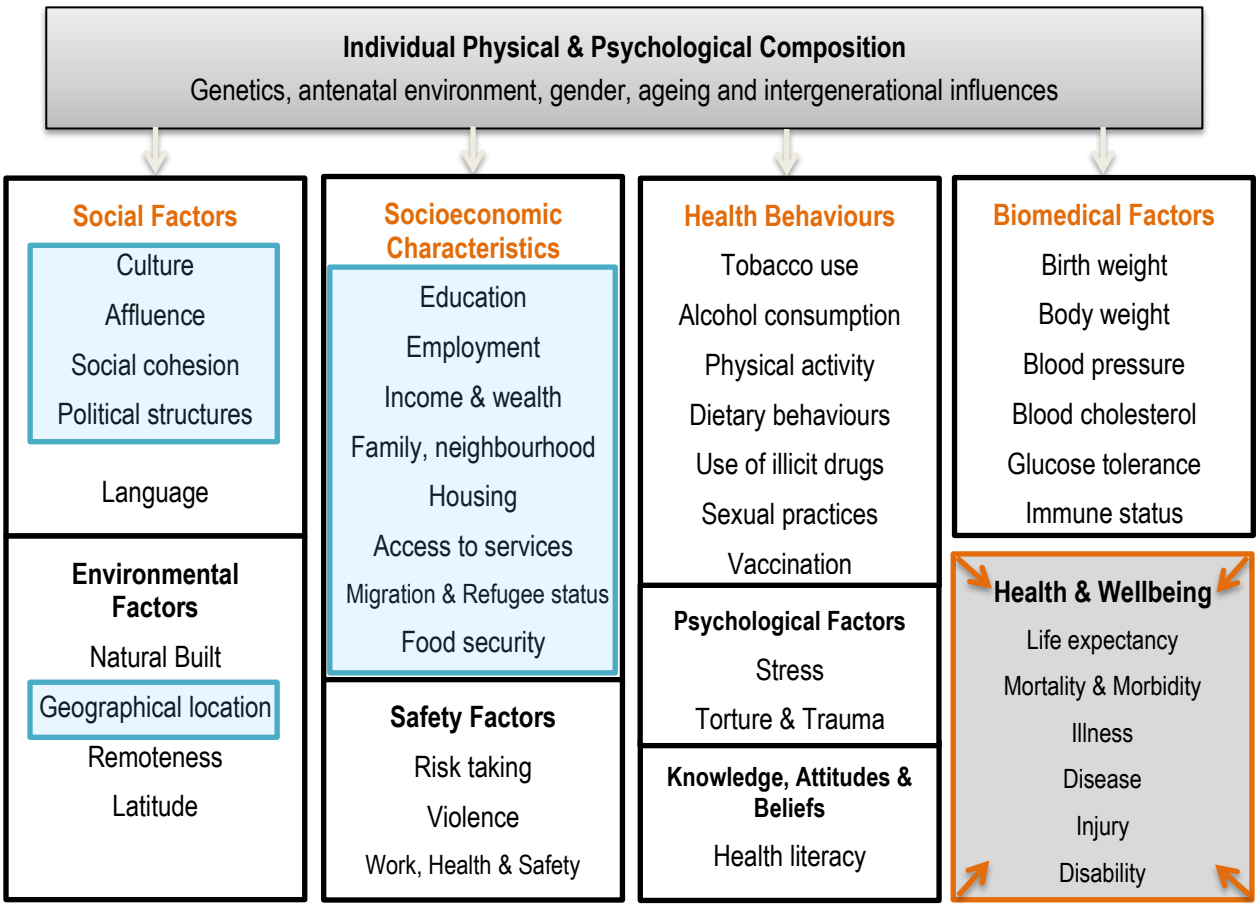
Health is extremely complex, involving a multidimensional interface between biology, lifestyle, socioeconomic and environmental factors, which can be influenced to some extent by a range of interventions (AIHW 2014). Previously dominated by a biomedical approach, health and social determinates are increasingly coming to the forefront (Keelen *et al* 2008). This section describes the foundations of heath and the principles of health promotion, to lay a platform on which to evaluate the FHP. Health is defined by the World Health Organisation (WHO) as:

> *'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'* (WHO 1946).

Determinants of Health

This section provides an overview of health describing the various factors that influence health. The Australian Institute of Health and Welfare (AIHW) 2014), divides determinants into four compositions. As outlined in Figure 1, the charter flows from 'upstream' (background) factors, which include culture, policies and environment, through to the more immediate (downstream) factors, such as body weight and blood pressure (AIHW 2012: 4; AIHW 2014: 5). The FHP focused its attention on social and environmental factors with the aim of modifying health behaviours, in a health promotion paradigm.

Figure 1 Charter for the determinants of health



Source: adapted from AIHW (2014: 5) and AIHW (2012: 4)

In more recent years there has been an increased understanding of the importance of the social determinants of health (WHO 2013). Social determinates of health encompass the social, economic, political, cultural and environmental determinants, as depicted in blue in Figure 1. According to the World Health Organisation (WHO), *'the social determinants of health are mostly responsible for health inequities,* that is*, the unfair and avoidable differences in health status'* (WHO 2013:2). The wealthier and more educated one is, the healthier they are, as they are able to afford better food and housing, better health care and are better informed about health behaviours and choices (WHO 2014).

The WHO defines risk factors as:

> *"A risk factor is any attribute, characteristic or exposure of an individual that increases the likelihood of developing a disease or injury"* (WHO 2013).

Table 1 presents ten risk factors in Australia.

Table 1 Risk Factors

Daily Smoking	Smoking tobacco products on a daily basis
Risky/high risk alcohol consumption	An average daily consumption of more than 50mls for males and 25mls for females
Physical inactivity	Not achieving the recommended amounts of physical activity of 150 minutes per week over at least five days
Insufficient amounts of fruit	Usual consumption of two serves of fruit per day (three serves for those aged 15–17)
Insufficient amounts of vegetables	Usual consumption of fewer than five serves of vegetables per day (fewer than four serves for those aged 15–17).
Fat intake	Defined as the usual consumption of whole milk
Obesity	Defined as having a body mass index (BMI) of 30 or more.
Large waist circumference	A measure of, or greater, than 94 centimetres for men and 80 centimetres for women
High waist-hip ratio	A measure of 1.0 or more for men, and 0.85 or more for women
High blood pressure	Based on respondent's self-reports of having high blood pressure as a current and long-term condition, or currently taking medication for high blood pressure

AIHW 2012

It is well documented that disadvantage has a negative impact on health with socioeconomic factors being important determinants of health. In general, relatively disadvantaged members of the community live shorter lives and have higher rates of illness, disability and death than those who are relatively advantaged (AIHW 2012). The AIHW (2012) findings show that people who live in socioeconomic disadvantaged areas are less likely to be physically active and more likely to smoke (AIHW 2012). Behavioural risk factors are those that are open to change by individuals, and are often the main focus of primary health and health promotion activities.

Since the Ottawa Charter in 1986, there has been mounting interest in developing approaches in health promotion which addresses risk taking behaviours and the social, economic and environmental determinants of health (Gills 1998).

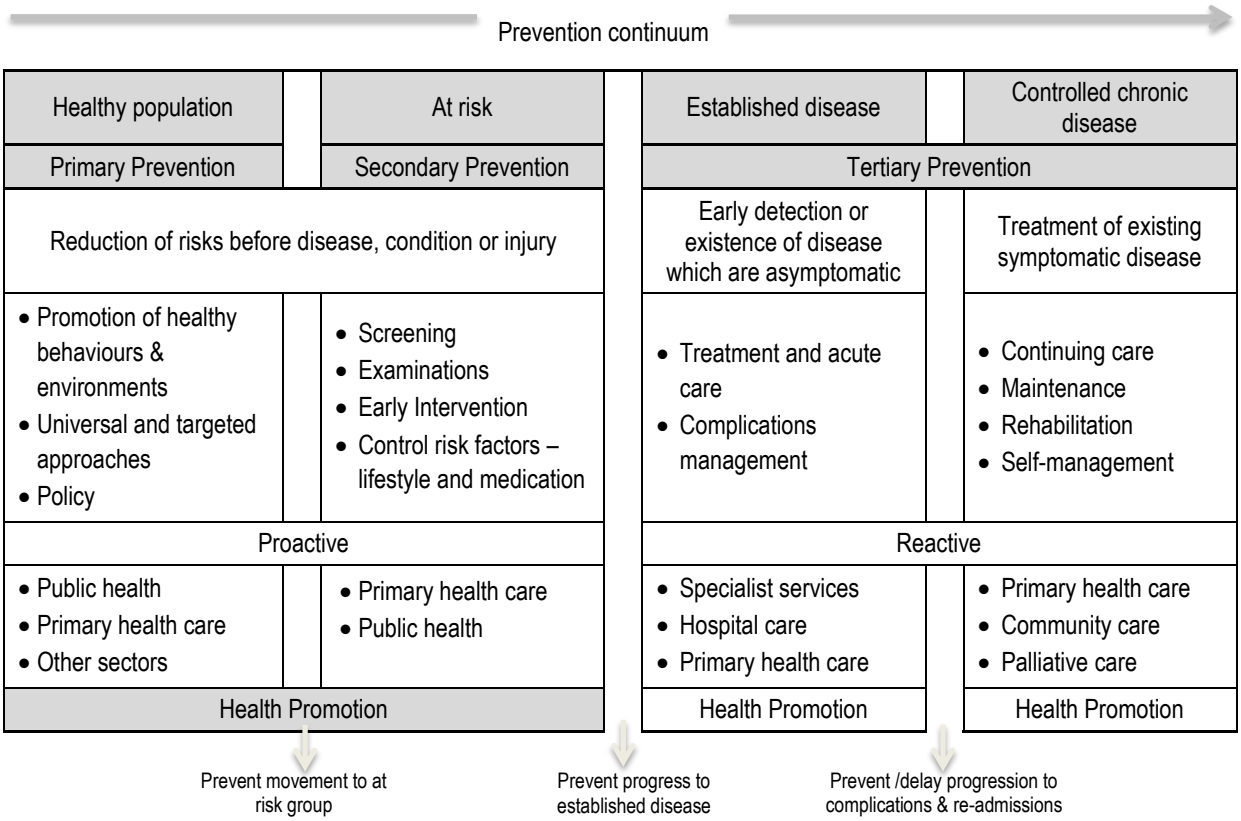
Health Prevention and Health Promotion

The World Health Organisation (1986) defines prevention as *'approaches and activities aimed at reducing the likelihood that a disease or disorder will affect an individual, interrupting or slowing the progress of the disorder or reducing disability'*. The specific characterisations of prevention are (AIHW 2014):

- Primary prevention - reduces the likelihood of developing a disease or disorder.
- Secondary prevention - prevents or minimises the progress of a disease at an early stage.
- Tertiary prevention - halts the progression of damage already done.

Figure 2, presents a structure for action and control across the spectrum of prevention.

Figure 2 Structures for Prevention



Adapted IEPCP 2016

Health promotion is the process of enabling people to increase control over and to improve their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions (WHO 1986). Evolving from the Ottawa Charter of 1986, five core strategies continue to guide the direction of health promotion in practice being: building healthy public policy; creating supportive environments; strengthening community actions; development of personal skills; and reorientation of health services (WHO 1986:2-3).

Health promotion's focus is on prevention (upstream) rather than intervention (downstream), with an emphasis on the social determinants of health, health risk factors, reducing inequity and addressing needs of the most disadvantaged (IEPCP 2016). Understanding health promotion principles is essential to the evaluation of the FHP.

The role of Local Government in Health

All levels of government, private practitioners and not-for-profit organisations have a role in the health and wellbeing. The Federal Government funds Medicare and the Pharmaceutical Benefit Scheme. The State Government carries key responsibility for hospitals and key medical services. The private sector provides medical, specialists and hospital services. Table 2 summarises some of the main functions illustrating the complexity of health arrangements. The role of LG varies depending on community needs and expectations, as described below.

Table 2 Governance functions for health systems in Australia

Function	Commonwealth	State/Territory	Local Government	Private / NGO Sector
Ownership		Public hospitals Community & public health	Community Facilities (Parks and Community centres)	Private Hospitals Aged Care facilities General Practitioners
Funding	Medicare Pharmaceutical Benefits Aged care Insurance rebates Dental Veteran's health NDIS	Public Hospitals Community & public health Ambulance Public dental Disability Care Immunisation	Waste Services Food Inspections Health & fitness Recreational facilities Bicycle paths Walking tracks	Health Insurance Accident Insurance
Provision Services	Australian Hearing C'wealth Rehab services Health Services Aust.	Accident compensation Public Hospitals Community & public health Ambulance Immunisation Allied Health	Immunisation Waste Services Food Inspections Health & fitness Recreational facilities	Private Hospitals Private Practice Aged care facilities Neighbourhood centres Allied Health
Regulation	Policy Therapeutic Goods Administration	Public & private hospitals Public health – food safety WHS	Public Health - Food safety, body piercing premises, cooling tower inspections etc.	

(Adapted Dwyer and Edgar 2008; AIHW 2014 and FCC 2012)

As depicted, health is extremely complex with multiple players responsible for different overlapping elements. Understanding health responsibilities is made even more difficult, with LG services differing in function and jurisdictions, depending on local needs and resourcing capacity. Some councils limit their functions to those prescribed in legislation while others provide direct health services to their communities (AIHW 2014).

Councils have a regulatory responsibility in public health (*Public Health Act 1991*) in relation to food safety, waste management, sewage management, water quality and legionella. Councils have a significant influence on environmental determinants of health through urban planning, infrastructure and community services (Rantala et al 2014).

Local government planning and provision of basic infrastructure and facilities that enables residents to participate in physical activity, is widespread (Whittington 2004). Local government provides recreation facilities and infrastructure such as parks, sporting grounds, cycle-ways, community centres and leisure centres which encourage healthy living and create healthy environments.

While some caution needs to be exercised, in essence LG in NSW spends 32% of its expenditure on health related services. This includes 16% or $216.14 per capita on recreation, 11% or $145.87 per capita on community services and 4% or $61.49 per capita on public health and safety (OLG 2015).

Health promotion is often not seen as core business of LG (King 1999), with participation in initiatives such as injury prevention, cancer prevention and active communities (physical activity and nutrition) being less common (Whittington 2004).

Social research on community attitudes, found that there was strong support for the role that LG plays in improving health and wellbeing and that public value[2] is becoming more central to LGs role:

> *"There is strong support for the role of government in service delivery, particularly in health and education. There is enormous support for government to provide services that deliver a healthier and fairer society, and for the view that decisions about services should not be made just on value for money. Australians agree that governments should be actively seeking to deliver public value". (Ryan R et al 2015:ii)*

Recent changes to the *NSW Local Government Act* further recognise the important role, LG plays in health. This along with a focus on co-operative partnerships will underpin LG's responsibilities in the future.

Why Health Partnerships?

The concept of HPs is widespread and there is no shortage of theoretical frameworks on how to do partnerships (Dowling *et al* 2004). Partnership is a nebulous concept, subject to numerous interpretations and regularly used interchangeably with collaboration, alliance and coalition, amongst other phrases (Riggs *et al* 2013).

Partnership as a way of improving health has been built on the underpinning that no single organisation has control over the determinants of health (Schoen *et al* 2014). *Bryson et al* (2006) characterises cross-sector partnerships as "*the linking or sharing of information, resources, activities, and capabilities by organisations in two or more sectors to achieve jointly an outcome that could not be achieved alone" (Bryson et al 2006:44).*

Partnerships between health agencies and LG are universally considered best practice and have been adopted since the early 80's (Hayes *et al* 2012). The WHO (2012) defines partnership as "*a voluntary agreement between two or more partners to work cooperatively toward a set of shared outcomes"*. However, the literature offers no consensus on a definition (Glendinning 2002 and Sullivan & Skelcher 2002). Accordingly, an inclusive rather than restrictive definition of partnership has been adopted. A HP is defined as:

> '*a joint working arrangement where partners are otherwise independent bodies cooperating to achieve a common goal; this may involve the creation of new organisational structures or processes to plan and implement a joint program, as well as sharing relevant information, risks and rewards'* (Dowling *et al* 2004:310).

Glendinning (2002) argued that the absence of a comprehensive definition is advantageous, as it enables flexibility and responsiveness which allows solutions to be developed based on the capability and degree of trust between partners. Cross-sector partnerships involve some reorientation and extension of partner organisations usual activities. Riggs describes this difference as: multi-sector refers to the desire to coordinate the activities of partner agencies; while inter-agency partnerships involves some dissolving of independence in common and co-operative efforts (Riggs et al 2013).

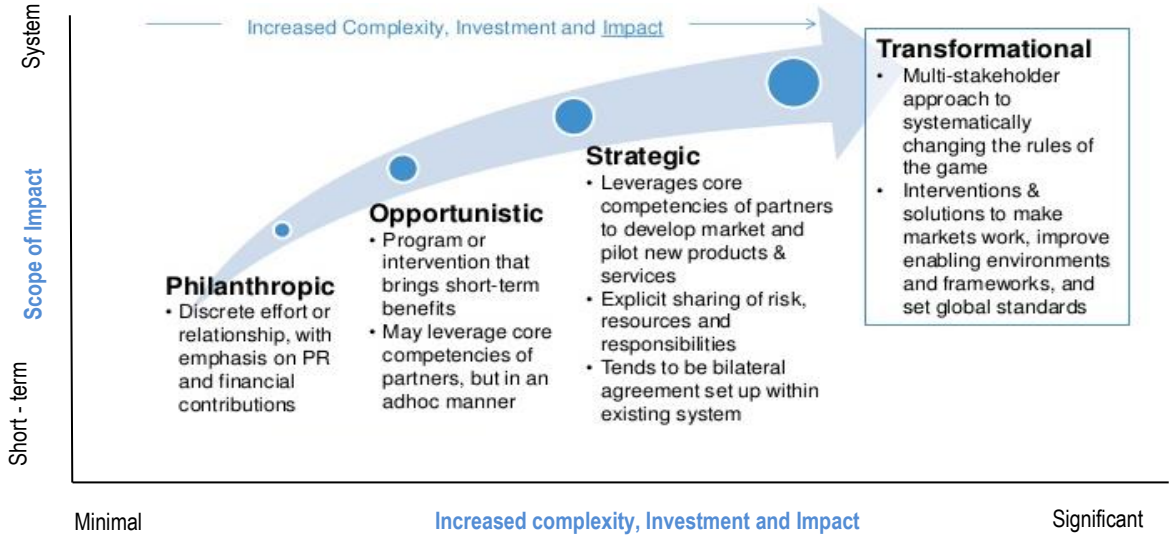
O'Donnell delineates functions of partnerships as ranging from network information and contracts to the formal transfer of functions and integration (O'Donnell 2012). Riggs similarly derives that partnerships operate on a multifaceted continuum from (Riggs *et al* 2013:4):

→ networking: exchange information.
→ coordinating: altering activities for mutual benefit and to achieve a common purpose.
→ co-operating: sharing resource for mutual benefit and to achieve a common purpose.
→ collaborating: enhancing the capacity of another for mutual benefit and to achieve a common purpose.

[2] Public Value is the combined view of the public about what they regard as valuable, in part it's about democracy and accountability (Moore 1995)

Collective Impact is an emerging model for creating larger scale partnerships and has five core tenets: a shared agenda, shared measurement systems, mutually reinforcing activities, continuous communication, and a central infrastructure (Flood *et al* 2015). The United Nations Transformational Partnership Framework (Figure 3) provides a theoretical account of partnership identifying four functions of partnerships: philanthropic, opportunistic, strategic, and transformational.

Figure 3 Transformational Partnership Framework



Adapted from UN Global Compact: 10 and BSR 2012:10

As outlined in Figure 3, the most impactful partnerships are those that are transformational as they are long-term, create system-wide impact and create capacity to reach scales and create lasting impact (UNGC; BSR 2012).

Cross-sector partnerships are critical for addressing social determinants of health and health inequalities by addressing problems through building shared knowledge, designing innovative solutions and forging consequential change (Norris-Tirrell and Clay 2010).

Norris-Tirrell and Clay (2010) outlined that moving from silos to collaboration requires managers to think differently about working beyond disciplines and sector boundaries. The purpose of creating and sustaining cross-sector partnerships ought to be the fabrication of 'public value' (Moore 1995) that cannot be created by single sectors alone. Leung 2012, identified that cross-sector partnerships enables 'collaborative advantage' whereby organisations working together generate something greater than the sum of their parts. Partnerships to improve health are embedded into practice however critical questions are raised about the extent to which HPs actually add value in terms of changing health behaviours.

There are many challenges in evaluating partnerships, including documented difficulties in attributing successful outcomes to partnerships or whether benefits outweigh the costs of partnerships (Riggs *et al* 2013). Furthermore, different partners may attribute different weights and meanings to the multiple dimensions on which the success of partnerships might be evaluated (Dowling *et al* 2004). A full assessment of Australian and international literature of the effectiveness of HPs follows.

Chapter 2

Literature Review

This chapter undertakes a review of Australian and international literature analysing the characteristics of effective HPs (process) as well as any influence partnerships have on improving health related behaviours (impact). The literature review provides a descriptive account of:

- Structures and processes required to build successful partnerships (process);
- Synthesises and critiques methodologies for evaluating the effectiveness HPs;
- Presents the key findings regarding the effectiveness of partnerships on improving health related behaviours (impact), especially in a LG context; and considers the
- Implications of the findings on the LG sector.

Search Strategy

A variety of keyword descriptors were used in searching online databases including search term of health promotion partnerships, HP, collaborative HP, health alliance, effective HP, joined up governance, collective impact and LG health promotion partnerships.

A total of seven databases were searched for publications from 2000 through to the present, with key articles obtained primarily from PUBMED /public health, MEDLINE, HEALTH-STAR, Healthcare management forum - SAGE Journals Online, Health Promotion Journal of Australia, International Journal of Public Administration and Cochrane Public Health Library. Additional articles were also identified throughout the reading and explored as part of this literature review. These articles were obtained via the UTS Library. Figure 4 provides an account of the search strategy including inclusions and exclusions.

Inclusion Criteria

The following inclusion criterion was considered to narrow the literature review:

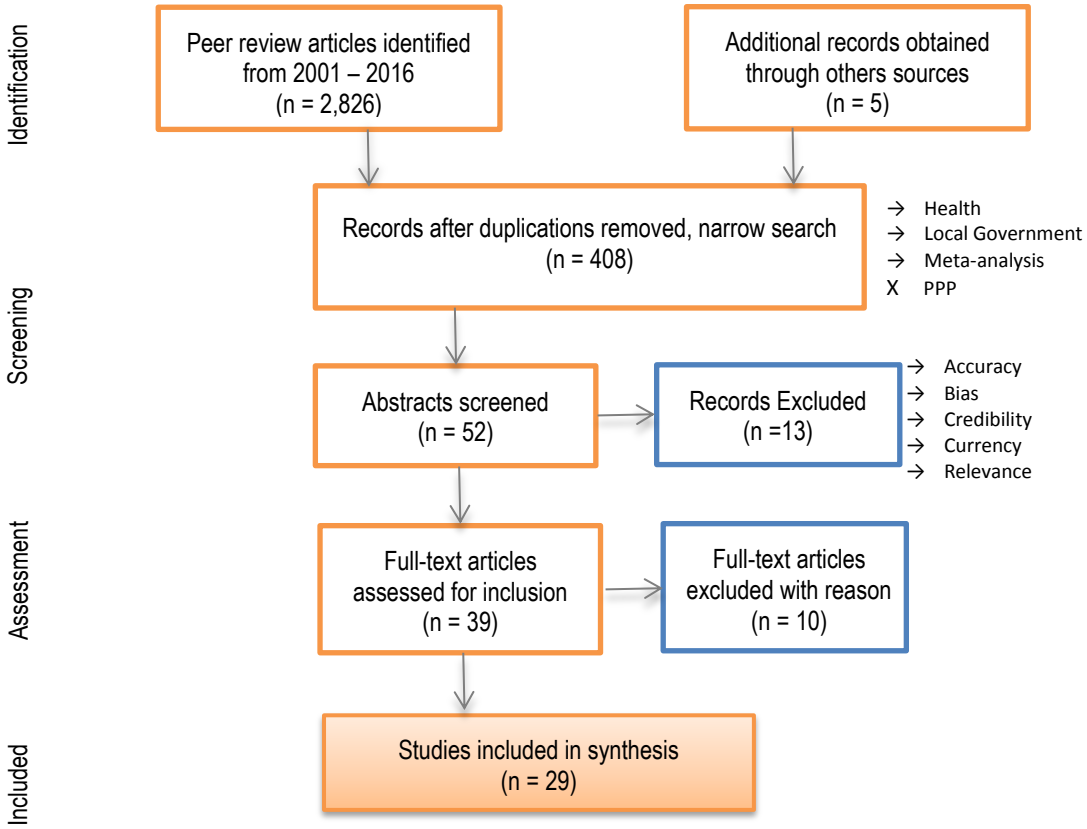
- Initial searches were limited to systematic and meta-analysis reviews however were later extended to include narrative reviews.
- Included international perspectives including US, UK, Canada and Australia.
- HP which focused on early intervention and prevention.
- A particular focus was placed on studies or reviews conducted within a LG context.
- An evaluation of the model had been carried out.
- Published since 2000.

Exclusion Criteria

The following were excluded from the literature review:

- Public Private Partnerships.
- Articles where partnership primarily involved grants or funding.
- Poor quality methodology (accuracy, bias, credibility, currency and relevance).

Figure 4 Search Strategy



Results of Literature Search

In all, 2,826 references were identified from the searches and five more from additional sources, of which 408 abstracts were reviewed. The full texts of 52 papers were read of which 13 were excluded. Twenty-nine papers were included in the final review. The majority of studies (n=24) evaluated effectiveness of HP (process) while only five articles touched on health impacts. In addition, reviews of six tools, which assess the effectiveness of partnerships, were also appraised which informed the methodology of the evaluation of the FHP.

There is no shortage of theoretical frameworks on how to undertake partnerships (Dowling *et al* 2004). The initial investigation identifies a plethora of international tools which outline how best to establish and facilitate a HP, however few if any, evaluate the cost or changes to health behaviours (Watson *et al* 2000). The following summarises the international literature on HPs, a comprehensive literature review is presented in Attachment 3.

Factors affecting the validity of these conclusions

The literature identified a wide range of HP building factors which were clustered on related characteristics. While, articles were selected on available meta-analysis records, the majority of articles identified limitations, due to the lack of rigour in the initial evaluations. This may in part be due to the difficulty in measuring the effectiveness of HP, the ability to attribute outcomes in uncontrolled environments and principally due to the fact, that many research articles have a limited timeframe and are often too recent for definitive conclusions to be drawn on any changes to health related behaviours.

In undertaking this review, some significant gaps in the published literature on the effectiveness of HP became apparent with little literature exploring impacts on health outcomes.

Foundations of Effective Partnerships - Process Evaluation

Determinants of successful HPs are those factors which influence the ability of a partnership to combine the perspectives, resources and skills to produce desired outcomes. Determining elements of effective partnerships may act as enablers or barriers to successful partnerships.

Hayes *et al* (2002) suggests that partnerships between health and LG are considered best practice, finding value with the participatory and broad based processes. Mitchell *et al* (2000) identifies three key elements to successful HPs as being ownership, contractual relations or alliances and informal interaction, identifying that trust and reciprocity were the underlying foundation to successful HPs. Graham *et al* (2015) identifies four areas where partnerships have been most effective being: fostering knowledge exchange; facilitating community-based research; moderate behavioural change; and capacity building and improving resources. Asthana *et al* (2002) determined that a key outcome of HP was the progress made in terms of shared principles, knowledge and understanding, however evidence on how best to generate organisational change was lacking.

The literature identified numerous factors to predict the success of HPs. These include: power and control commitment; trust; resource sharing; managerial commitment; clear communication and agreed deliverables. The Martin-Misener and Valaitis (2008) framework identifies three types of determinants that influence the success of partnerships systemic, organisational, and interpersonal.

The literature identified four themes required to build successful HPs being governance, organisational, individual and achievement and accountability capabilities. For effective integration, research found that partnerships must happen at *'multiple levels and be supported by a range of cultural and structural interventions which are supported at multiple levels, from strategic political commitment throughout collaborative practitioner relationships at the street level'* (Carey & Crammond 2016:1022).

The most recognised foundations of effective HPs which were identified in more than six articles, in order of importance were Shared Vision; Commitment; Trust; Power & Control; Communication; Shared Resources; Evaluation, Relationship and Leadership. Drawing on the literature, the foundations of effective partnerships are presented in Figure 5 and are further described in detail below.

Figure 5 Elements required to build effective partnerships

Governance Capability

Commitment: Commitment was identified in 12 articles and appears to be most effective when HPs are supported at multiple levels. Strategic commitment from politicians was universally regarded as key (Carey & Crammond 2016) with an emphasis that partnerships must capture 'politicians' interest' and sustain 'political visibility' (Gilles 1998) to gain and maintain support from elected officials. To address this challenge, Koelen *et al* (2008) suggest that HPs should not just focus on health outcomes but also on short-term and immediate changes.

Power & Control: Key features of interpersonal relationships that foster collaboration include trust, respect and creating a fun environment (Koelen et al 2012; Lasker et al 2001; Cameron et al 2014). HPs are more likely to succeed when they build in resources and strategies for dealing with power imbalances and shocks, as power inequities are a source of mistrust (Bryson et al 2006). Partnerships bring together professionals and organisations with different philosophies and values (Cameron et al 2004) with separate entrenched bureaucracies (Martin-Misener & Valaitis 2008). Power imbalances become significant when partners have difficulty agreeing on a shared purpose (Koelen et al 2012).

Organisational Capability

Shared Vision: Failure to clearly define the values and mission can create tension between partners and reduce the effectiveness and sustainability of the partnership (Koelen *et al* 2008; Lasker *et al* 2001). Effective HPs require a shared jargon-free (Lasker *et al* 2001) vision for change, including a shared understanding of the problem and shared solution (Flood *et al* 2016). Developing governance arrangements that formalise membership, how partnerships make decisions and undertake their work shapes the extent to which perspectives, resources, and skills can be combined (Lasker *et al* 2001). Koelen *et al* (2008) Finding show that partnerships can succeed if participants agree on the problem, the aims and objectives, the roles and responsibilities and the strategies and procedures.

Shared Resources: Partnerships are created by making use of each partner's strengths while finding ways to minimise and overcome characteristic weaknesses. Shared funding and sharing resources in relation to information, funding, human and technical resources has been widely highlighted as a way of increasing partner involvement (Koelen et al 2012; Roussos and Fawcett 2000).

Relationships: The relationship between partners was identified as an overriding factor of the success of partnerships (Keolen *et al* 2012) as partners bring personal characteristics and opinion, that is attitudes, beliefs, self-efficacy, social identity and personal relationships (Dowling *et al* 2004). Communication between parties works best when there is a combination of formal and informal communication. Conversely, disliking partners, on a personal level, makes partnerships burdensome and ineffective (Koelen *et al* 2011).

Individual capability

Leadership: Strong leadership at all levels emerges from the literature as essential for successful HPs. O'Donnell (2012) argues that leaders in multidisciplinary partnerships require different skills than traditional leaders. The need for strong leaders at all levels emerges from the literature. Successful partnerships are characterised as having *"leaders who work to create a supportive, trusting cultures conducive to problem solving, where staff are free to find 'work-arounds' to problems" (Carey & Crammond 2016:1024).*

Partnerships 'need boundary-spanning leaders' who can 'understand and appreciate partners different perspectives, can bridge diverse cultures, and are comfortable sharing ideas,

resources and power' (Lasker *et al* 2001:193). The literature highlighted that the leader was an architect rather than a delegator, showing the importance of combining perspectives and producing partner buy-in (Lasker *et al* 2001; Roussos and Fawcett 2000).

Trust: Successful HPs involves high levels of trust, reciprocity and respect between partners (Dowling *et al* 2004). Partnerships are more likely to succeed when trust-building activities, common bond and sense of goodwill are constant (Bryson *et al* 2006). Mitchell & Shortell (2000) identified three major mechanisms as ownership, contractual relations and informal interactions are characterised by norms of trust and reciprocity. Partners build trust by sharing information and knowledge, exhibiting competency, good intentions and follow-through (Bryson *et al* 2006).

Communication: Effective communication strategies and mechanisms to facilitate partner activities are needed to synergise thinking and action. (Lasker *et al* 2001). Developing effective communication between partners was identified as a key challenge, due to the nuanced understanding of differing demands, language and culture (Riggs *et al* 2013). Partnerships require an open-minded approach, actively learning and innovative organisations that are willing to go beyond the norm, where resolved conflict can lead to a stronger relationship through improved communication (Koelen *et al* 2008).

Achievement and Accountability Capability

Evaluation: Evaluation of HP activities is cited in the literature as a key factor to the success and sustainability. Bryson et al 2006 argued that the purpose of partnerships was to produce 'public value' that cannot be achieved by a single organisation. It is impossible to know whether your partnership has been a success unless you have evidence of a change, which is necessary for gaining political and managerial support (Roussos and Fawcett 2000).

Health Impacts – what the evidence tells us?

It is often claimed that HPs should be measured in terms of their health outcomes rather than the processes. International studies show there is a lack of tangible evidence to support that HPs have any measurable effect on health (Rummery *et al* 2002; Rousos *et al* 2000; Graham *et al* 2015). Only a few articles have focused on the impacts of HP and there is no reliable evidence that partnerships necessarily improve health related behaviours (Hayes *et al* 2012; Dowling *et al* 2004; Graham 2015; Rousos *et al* 2000; and Martin-Misener and Valaitis 2008).

Hayes *et al* (2012) findings did not identify any reliable evidence that interagency collaboration, compared to standard services led to health improvement, concluding that only one study showed a modest improvement that may have been a result of significantly more resources. Rousos *et al* (2000) concluded that there was insufficient evidence to make strong conclusions about the effect of partnerships on population-health outcomes, with Schoen *et al* 2014 concluding that further research was required to define the causal linking between partnerships and its relationship to health outcomes. Rummery *et al* (2002) longitudinal studies also showed little evidence of any changes to health. Graham (2015) describes flexibility and responsiveness as one of the greatest assets, which shape the underpinnings of HPs, however this presents a quandary for researchers.

The reason for the lack of evidence is partly due to a number of challenges associated the social research environment. Firstly, empirical studies have failed to make any causal link between HPs and health outcomes (improved health or quality of life). It has been recognised that health needs to be measured in the long-term which may be difficult to attribute back to HP. Secondly, it is difficult to assess the counterfactual, such as what might have transpired in the absence of the partnership (Dowling *et al* 2004).

Discussion

The literature identified the need for sounder evidence to justify and prove the effectiveness of HPs. Research into HPs centres heavily on process issues, with little emphasis given to outcome success. A constant theme throughout the literature was the challenge of evaluating in a population setting (Dowling *et al* 2004).

Many argue that the lack of evidence is due to the difficulty in evaluating structures and collaborations (Schoen *et al* 2004), and that continued investment in research on HPs is required. Dowling *et al* (2004) identified the need to broaden the research to include analysis of the cost effectiveness, suggesting that measuring short and medium term behaviour changes may be more effective, avoiding the challenges of measuring and attributing health outcomes over the long-term.

There is no doubt that the lack of evidence is partially due to the difficulty with evaluation methodologies. As suggested by Bauld *et al* (2010) evaluating HPs is complex and challenging, arguing that 'primacy of experimental approaches for evaluation is often inappropriate for social interventions'. Bauld *et al* (2010) offers an alternative evaluation methodology whereby suggesting a triangulation approach be adopted to measure the complex links between activity and contexts of HPs.

The evaluation of the FHP endeavoured to fulfil the gap in the literature as it provided a unique opportunity to evaluate the effectiveness of the HP over two decades, to determine if working together has resulted in outcomes, than if we didn't work together.

Evaluation– What Is It?

Conducting high quality research allows increased capacity to predict what could be achieved through HPs as it provides increased accountability for program inputs and activities undertaken by measuring any change to individuals, communities and organisations.

Evaluation is the process of making a value judgment and determining the extent to which it has achieved its intended outcomes and the practices undertaken to achieve those outcomes (Hawe *et al* 1990). Atkinson 2005 considers evaluation as a form of applied research concerned with describing real world problems and seeking solutions to such problems. Its purpose "*is to assess the effects or effectiveness of something, typically some innovation or intervention: policy, practice or service"* (Atkinson 2005:1).

A program logic model has been adopted to demonstrate the input and outputs of the FHP. The program logic model aims to measure the process and impacts, defining the casual chain of events that have led to any change. The following definitions are presented *(*Nutbeam, D. 1998; Hawe et al 1990)

- *Process evaluation* - measures what extent a program has been implemented, by assessing reach, participant satisfaction, implementation of activities, performance of intervention and quality assurance.
- *Impact evaluation* - concerned with the immediate short-term effects and reach of the program, generally measures achievement of program objectives
- *Outcome evaluation* - measures long-term effects, whether a program has achieved its goals
- *Effectiveness* - the ability of an intervention to achieve its intended effect in normal conditions.

The evaluation of the FHP adopts an ex post facto evaluation framework, to reveal cause-and-effects of any change. The ex post facto evaluation methodology used data already collected, meaning what is done afterwards (Simon and Goes 2013). In order to determine if the FHP made a difference, the next Chapter presents the epidemiological data for Fairfield residents, so as to provide a platform on which to compare any changes to health risk behaviours.

Chapter 3

About Fairfield City – Comparisons and Indicators

This section provides an overview of Fairfield City, including the demographical characteristics of residents and their health. Attachment 1 provides a detailed summary of the key demographics of Fairfield City in comparison to local government areas (LGA) in metropolitan Sydney, which have high levels of migration and disadvantage. According to the WHO, social determinants of health are mostly responsible for health inequalities (WHO 2014).

This Chapter elucidates causal factors using data to characterise social determinants of health. Understanding these factors is important as it informs the FHP by highlight the variations in health status between LGA. The section aims to identify a community of interest, so as to undertake a trend analysis to determine if the FHP has made a difference.

Fairfield City is located in Sydney's south west about 32 kilometres from the Sydney Central Business District. Fairfield LGA neighbours Blacktown, Holroyd and Parramatta LGAs in the north, Bankstown LGA in the east, Liverpool in the south, and Penrith in the west.

As of the 30 June 2015, Fairfield LGA had an estimated resident population of 204,442, (ABS 2015). Fairfield will continue to have significant population growth with a projected population of 243,651 by 2036 (id. 2016).

Fairfield City had a higher proportion of young people (0 to17 years) compared to Greater Sydney and a lower proportion of people in the older age groups (60+ years). Overall, 25% of the population was aged between 0 and 17, and 17.1% were aged over 60 years, compared with 22.9% and 18.0% respectively for Greater Sydney (ABS 2011).

As prevalence of chronic health conditions increases with age, it is likely, based on the age profile that Fairfield residents would most likely to have better health indicators than other Greater Sydney (AIHW 2012).

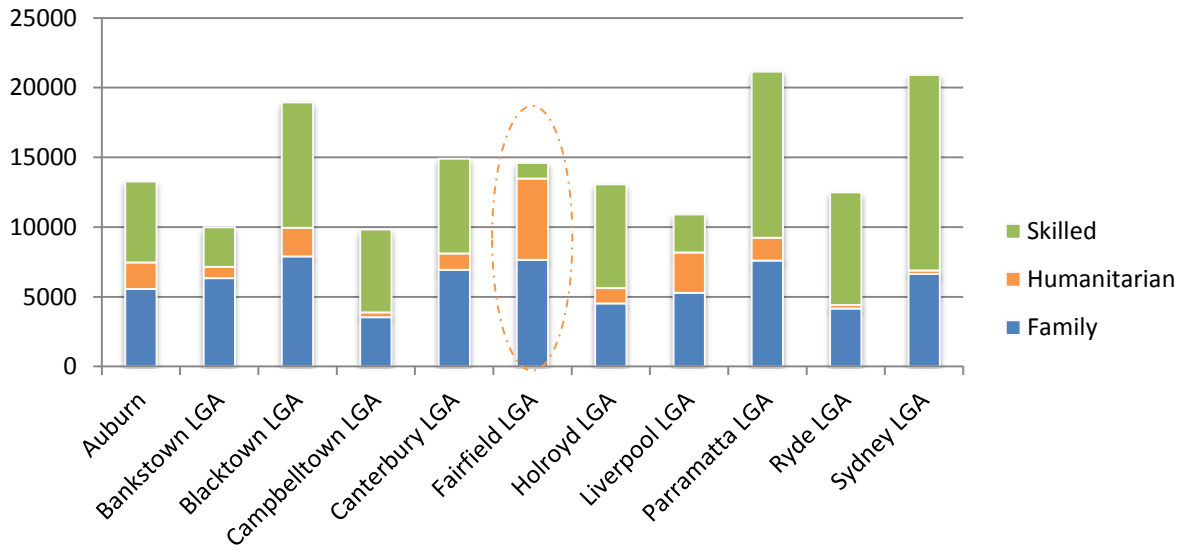
Cultural Diversity

Since the establishment of the first migrant camp at Cabramatta in 1951, Fairfield LGA has continued to settle waves of migrants (Id 2016). The City is rich in culture being one of the most culturally diverse communities in Australia with 52.5% of people being born overseas and 70% of people speaking a language other than English at home (ABS 2011). By contrast, the Aboriginal and Torres Strait Islander community of Fairfield LGA is estimated to be 0.8% compared to Campbelltown LGA and NSW which are 3.7% and 2.5% respectively (PHIDU 2015).

Fairfield LGA is the most popular place for settlement with the area welcoming a total of 14,624 migrants during the period 1 April 2010 and 31 March 2015. Fairfield LGA welcomed the highest number of Humanitarian Entrants[3] (5,816) in Australia, followed by Brisbane (3,862). Fairfield LGA had 7,660 migrants arriving on Family Visa, the fourth highest in Australia. During this period Fairfield LGA received only 1,146 skilled migrants compared to Brisbane, Parramatta and Sydney who received 42,017, 11,918 and 14,030 respectively. Figure 6 provides a comparison with other LGAs within Western Sydney that have high rates of migration (DSS 2016).

[3] Humanitarian Program: "is the Australian migration stream supporting resettlement of refugees and people in refugee-like situations. The Humanitarian Programme has two components: 'Offshore Resettlement' – for people outside Australia in need of humanitarian assistance, including 'Refugee' and Special Humanitarian Programme categories, both providing permanent resident status; and 'Onshore Protection' – for people already in Australia who are found to be refugees" (The Royal Australasian College of Physicians, May 2015 p 4).

Figure 6 Permanent Migration Arrivals by Local Government Area and highest NSW Migration Stream 1 April 2010 to 31 March 2015



As can be seen in Figure 6, Fairfield LGA has a much lower rate of skilled migration than the other areas, but the highest rate of humanitarian migration in Australia.

Humanitarian Entrants such as refugees[4] often have unique and complex physical and mental health needs that require specific healthcare (TRACOP 2015). Refugees are particularly vulnerable to poor health experience due to barriers such as cultural and language differences, economic obstacles that limit or prevent their access to healthcare (Murray & Skull 2005). Many refugees have had poor access to health care and have lived in poor conditions prior to arriving in Australia, resulting in a range of risk factors which place them at a relatively higher risk of poor health. These risk factors stem from their health history, health literacy, poor proficiency in English and behaviours and attitudes derived from their previous experiences of health care, which means that preventative health practices are not taken up and that preventative health care is not accessed (Benson et al 2007; Harris et al 2005; FCC 2010).

It is likely that based on ethnic profile of Fairfield LGA, that Fairfield residents would most likely to have poorer health indicators than other Greater Sydney areas (AIHW 2012).

Disadvantaged

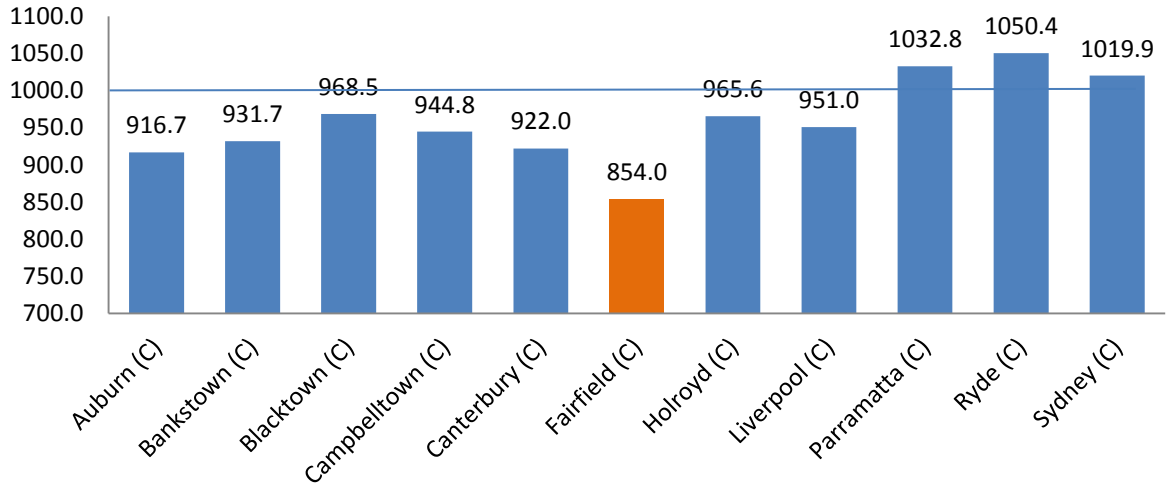
Health gains over the past few decades have not been equally shared with a gap widening between those with good and poor health, there is considerable evidence that social determinates play a critical role in health outcomes (NSW Chief Health Officer's Report 2010). Disadvantaged communities live shorter lives and have higher rates of illness, disability and death than those who are relatively advantaged. Disadvantaged areas are less likely to be physically active and more likely to smoke (AIHW 2012).

[4] Refugee: is someone who, "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his/her nationality, and is unable to, or owing to such fear, is unwilling to avail himself/herself of the protection of that country, or who, not having a nationality and being outside the country of his former habitual residence, as a result of such events, is unable or, owing to such fear, is unwilling to return to it." (The Royal Australasian College of Physicians, May 2015:4).

Fairfield LGA has 34.8% of households in housing stress and 24.2% in mortgage stress compared to Auburn who has 27.2% and 22.8% respectively, the next closest LGA in metropolitan Sydney. Fairfield LGA has more residents on the Aged Pension (81.6% of people who were age eligible) and Disability Support Pension (7.1%) than any other LGA in metropolitan Sydney area (PHIDU 2015). Overall, 25.6% of the population held educational qualifications, and 60.8% had no qualifications, compared with 43.0% and 42.8% respectively for the Sydney Statistical Division.

Fairfield LGA has a high level of disadvantage compared to the rest of Sydney and Australia (Figure 7). As outlined in Attachment 1 on all the indicators of disadvantage, Fairfield LGA demonstrates the poorest results.

Figure 7 SEIFA Index Score: Index of Relative Socio-economic Disadvantage 2011 in comparison to LGA's with high migration streams



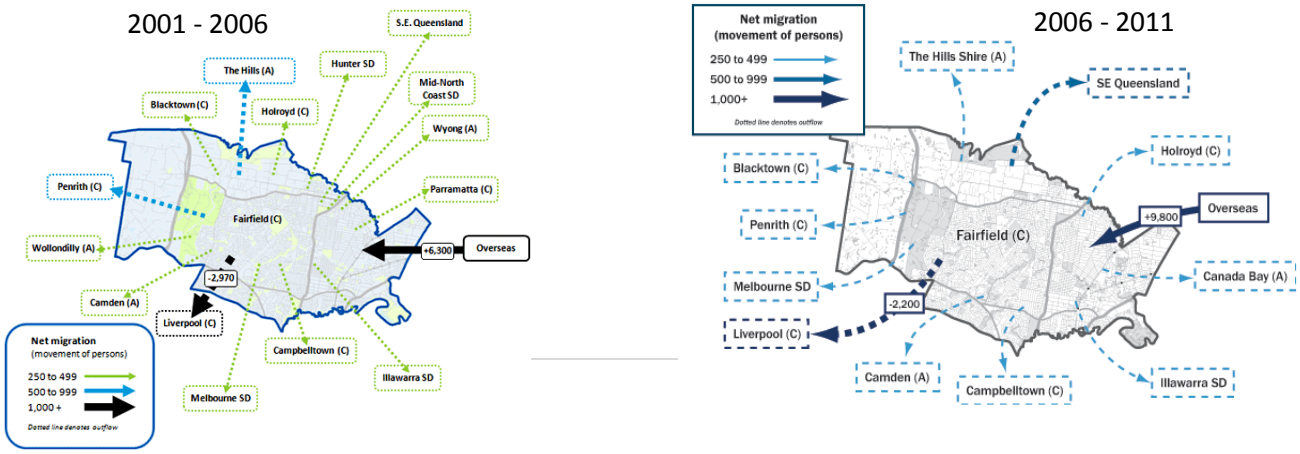
As can be seen in Figure 7, Fairfield has a SEIFA Index Score of 845, which makes it the most disadvantaged LGA in the Sydney metropolitan region. The level of disadvantage in Fairfield LGA increased from 876 in 2006 to 854 in 2011 (ABS 2011). Fairfield LGA is the third the most disadvantaged LGA in NSW behind Brewarrina and Central Darling who are both remote areas with large Aboriginal communities.

Based on disadvantaged profile, Fairfield residents would most likely to have poorer health indicators than other parts of Greater Sydney (AIHW 2012).

Population Movement

Fairfield City is known as a settlement City having received over 16,000 residents from overseas between 2001 and 2011, as portrayed in Figure 8 below.

Figure 8 Migration flows, Fairfield LGA 2001-2011



As can be seen in Figure 8, large numbers of residents have migrated to other LGAs from Fairfield LGA after a period of initial settlement in Australia, continuing to make way for new migration (Id 2016). Crucially, this pattern of migration and the constantly changing cohort of residents also producers challenges for the evaluation of the FHP.

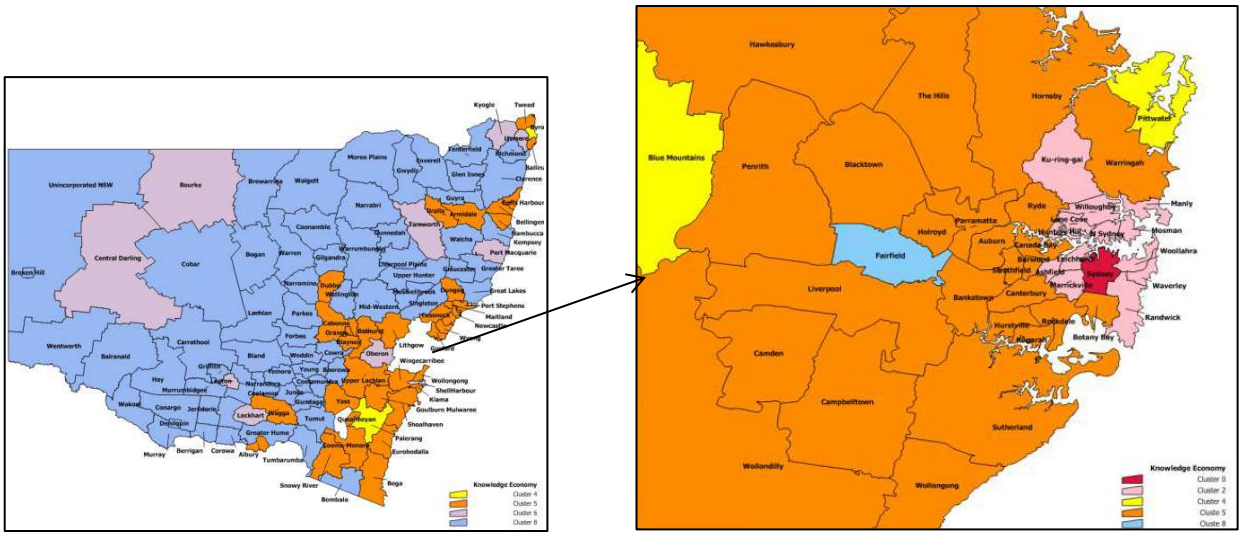
Similarities and Differences

The National Institute of Economic and Industry Research (NIEIR 2013) undertook a cluster/ factor analysis to determine LGAs with similar characteristics in NSW using 14 demographic and economic factors. LGAs were grouped into clusters where similarities were identified. Attachment 1 provides a comprehensive assessment of the 14 cluster areas.

On the basis of the analysis, Fairfield LGA was found to be unique, having little in common with neighbouring metropolitan LGAs. The report identified that Fairfield often had more in common with rural and remote communities than its neighbours. Out of the 14 clusters, Fairfield LGA was identified as having 50% similarity with Holroyd, Liverpool and Bankstown.

This analysis suggests that Fairfield LGA has specific and unique needs within Metropolitan Sydney (NIEIR 2013), for example, the 'Knowledge Economy' indicator showed that the Fairfield was cluster into a group who returned low values for all the listed indicators of 'Knowledge Economy'. The cluster grouping includes rural and inland LGAs and spreads from northern New England down to some of the North Coast LGAs as portrayed in Figure 9.

Figure 9 Knowledge Economy – clusters of similar areas



Fairfield LGA is the only metropolitan LGA grouped into this cluster. Similar to the SEIFA Index of Disadvantage, Fairfield City has much in more common with rural and remote communities and has unique qualities compared to other Sydney metropolitan areas.

Health Status

Fairfield LGA is in the lowest SES Quintile of the former Sydney South Western Area Health Service with a health ranking is 174 out of a total 175 LGAs. This means that only one LGA has a worse health profile than Fairfield LGA (FCC 2009). Attachment 1 provides detailed comparison of Fairfield LGA health indicators in comparison to neighbouring LGAs with high levels of migration and disadvantage.

Fairfield residents assess their health as 'fair or poor' at a much higher rate than people in Sydney and NSW. Fairfield residents generally suffer poorer health outcomes than other areas of Sydney and NSW with higher levels of Hepatitis B & C, diabetes, some cancers, disabilities and mental health issues (PHIDU 2015). Data from the Fairfield Hospital (FH 2014 p61) suggest the following:

- The prevalence of Diabetes is 7.2 %, compared with the NSW prevalence of 6.3%
- Rate of Hepatitis B notifications is 161.8/100,000 people (NSW 37.6/100,000). The rate of Hepatitis C notifications is 88.3/ 100,000 people (NSW 57.2/100,000)
- High body mass index attributable
- 13.2% reported high or very high levels of psychological distress (NSW 11.1%)
- Compared to NSW (100), Fairfield has higher rates of hospitalisations that are from falls related injury (106.2) and diabetes related (101.6)

Table 3 provides an overview of health behaviours of the residents of Fairfield LGA and NSW, which shows that Fairfield residents are less likely to drink alcohol and eat more fruit than NSW, conversely had poorer vegetable consumption, lower levels of physical activity and were more likely to smoke during pregnancy.

Table 3 Health behaviours of resident of Fairfield LGA and NSW aged 16 years and over 2008-2010

Indicator	Fairfield %	NSW %
Consumes 2 + standard drinks a day when drink alcohol	16.5	30.4
High risk alcohol drinking	4.0	9.5
Vaccination against influenza in the past 12 months by year	76.5	72.4
Recommended fruit consumption	59.1	56.1
Recommended vegetable consumption (at least 5 serves per day)	4.9	10
Adequate Physical activity	42.8	55.2
Current smoker	17.3	17.1
Smoking during pregnancy	111.7	100

Source SWSLHD 2014, p 9

As can be seen in Table 3, Fairfield LGA have socio-economic characteristics that would suggest poorer health indicators. However Fairfield LGA has better health behaviours in the areas of fruit and alcohol consumption and vaccinations and similar results in smoking.

Public Value

Consultations with Fairfield residents and businesses on the top ten priorities for Fairfield City by 2022, identified Better Health Services as the third highest priority (FCC 2012). The results demonstrated the importance of health for the community. The Fairfield City Plan 20012-2022 defines Goal 2 – Being Healthy and Active in Theme 1 Community Wellbeing as:

> *"We enjoy good health (physical, psychological, social and environmental), have access to high quality facilities and services and contribute to our own wellbeing through a healthy lifestyle".*
>
> *2.1 Accessible and affordable education services to support a healthy lifestyle*
> *2.2 Opportunities to access active, creative leisure and recreational services*
> *2.3 A healthy and safe environment*
> *2.4 Education and access to good nutrition for health and wellbeing*

The Fairfield City Plan (FCC 2012) identifies the following related strategies for achieving these goals:

- Supply medical and other health services that are accessible to meet community needs
- Provide a range of parks, sporting fields and recreation facilities and programs

- Make available activities, information and facilities to enjoy hobbies and leisure pastimes
- Establish standards, routine inspections and maintenance programs to ensure clean, healthy and safe public places, goods and services
- Provide information and education about healthy lifestyle programs including being sun-smart, nutrition, exercise, tobacco, drug and alcohol use, gambling, risk taking behaviours and mental wellbeing
- Provide preventative health services and programs
- Ensure people have access to health and culturally appropriate food

The resident of Fairfield LGA value health and identify it as high priority for the City.

Summary

The Chapter identified the demographic characteristics which effect health in order to identify a comparison-area for the evaluation of the FHP. Establishing counterfactual and comparing outcomes of the FHP, with an area with similar characteristics who have not received the intervention is becoming problematic. Fairfield LGA appears to be unique with its disadvantaged and migration characteristics. No-one area had similar characteristics, with Fairfield LGA more often having the poorest indicator for social determinants of health. If the comparison-area differs in key characteristics before statistical trend analyses are applied, it will most likely dilute finding, making them invalid.

For this reason, the evaluation of the FHP will undertake trend analysis using a number of comparison-areas in an attempt to demonstrate a pattern across a series of health indicators. For the purpose of Chapter 7, trend comparisons will be undertaken with Liverpool, Auburn, Blacktown, Holroyd and the Local Health District to establish if the FHP's impact in counterfactual outcomes. While there are numerous limitations to this method, undertaking an evaluation in a social environment is difficult in itself, nonetheless the realisation that Fairfield LGA is unique and the inability to identifying a single comparison-area further complicates the research. Conversely, by using a number of comparison-areas to counterfactual the FHP may strengthen the results.

Chapter 4

The Fairfield Health Partnership

Fairfield Health Partnership

Existing in various forms since 1995, the FHP established a formal collaboration between NSW Health and FCC. An audit of records was undertaken to determine the journey the FHP undertook.

FCC had files and records dating back to the inception of the FHP. An audit of these files was undertaken to obtain a detailed history of the FHP where numerous evaluation reports were identified. The audit identified the inputs and activities associated with the FHP throughout the 21 years which are described using a program logic model (Figure 13). Each file was manually reviewed and information summarised for the period. Information on membership, contract obligations, funding, minutes of meetings and evaluation reports were meticulously reviewed and summarised (FCC 2016).

Attachment 2 provides a detailed chronology of the FHP and its associated activities. The FHP has had its foundation established on evidence based practices forming the principles that underpin the partnerships longevity. As outlined in Chapter 3, four elements are required to build successful HPs being governance, organisational, individual and achievement and accountability capabilities, which are evident in the FHP. As Carey and Crammond (2016) established, successful partnerships must happen at multiple levels and must be supported at the strategic political, including the practitioner level.

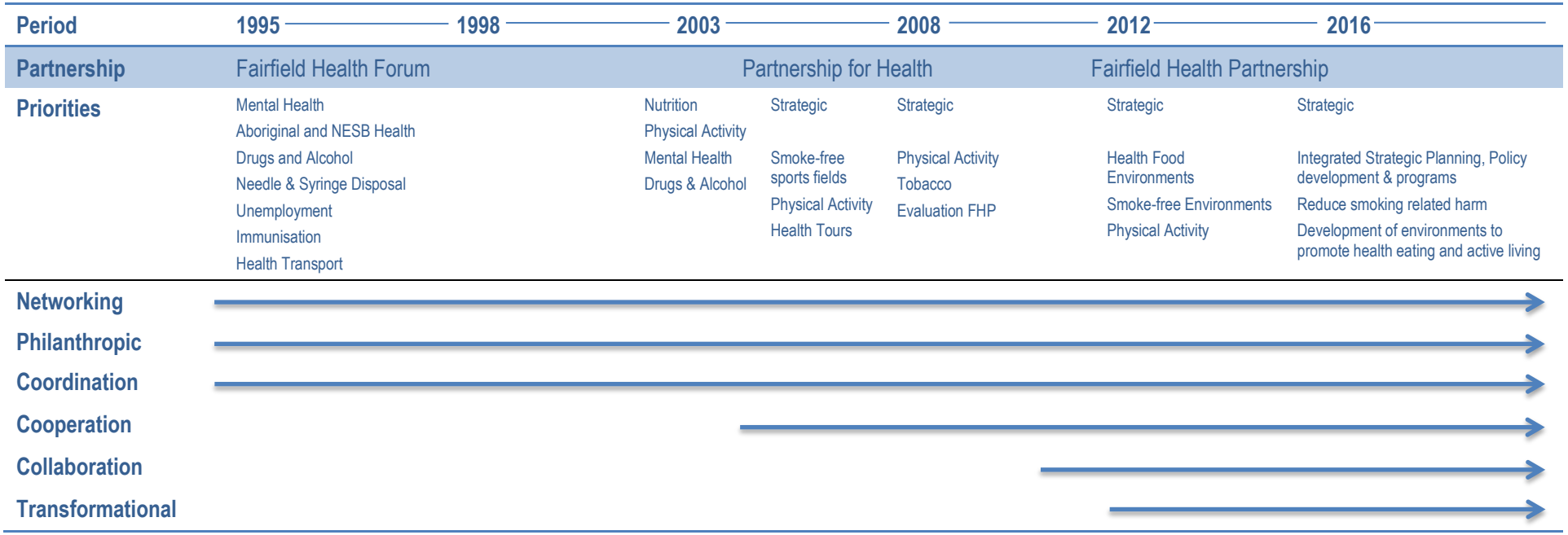
The FHP has embraced the elements of effective partnerships having shared vision and agreed priorities which are document through memorandums of understanding and terms of reference. The FHP has established a structure which includes executive and strategic working groups to ensure multiple level commitment and established clear lines of communication (Figure 10). A jointing funded project work, 21hr per week throughout the life of the partnership, has ensured that power and control remained somewhat equitable. The FHP has seen a total of $1,274,000 in funding shared equally amongst the partners over the life of the project. The FHP has also evaluated its successes along the journey (FCC 2016).

Figure 10 Structure of the FHP

The history shows the evolution of the FHP into three periods ('episodes'), are illustrated in Figure 11 which shows the level of complexity in the elements and functions of the FHP cumulating over time, which is discussed in greater detail below.

For the purpose of this research paper a program logic model was developed to further describe the elements of the FHP to demonstrate the inputs and activities to determine how success may be measured, which inform the research methodology (Figure 13).

Figure 11 – Chronology of the evolution of the FHP



Source FCC 2016

Drawing on the material contained in Attachment 2, the following provides an account of the FHP over the past two decades which has established the foundations of what the FHP has become today.

Episode 1 – The Fairfield Health Forum – Networking and Coordination

In 1995, the Fairfield Health Service and FCC established a formal partnership, in the form of the Fairfield Health Forum (Forum). The Forum membership comprised Fairfield Health Services, FCC, non-government organisations and residents. The first meeting of the Forum took place on the 17 March 1995. FHS and FCC jointly funded a part-time Community Project Officer, based at FCC for 21 hours per week. The role of the worker was to provide secretariat support to the Forum, research support and to undertake partnership projects under its umbrella (FHF 2002). The main aims of the Forum were:

- provide opportunities for the local community to share information;
- identify issues of concern; and
- develop strategies to address those concerns.

The priorities between 1995 -2001 were mental health, Aboriginal and non-English speaking health, with focus areas of drug and alcohol, needle and syringe disposal, unemployment, immunisation and health transport. In 2002, the priorities changed to nutrition, physical activity, mental health and drugs and alcohol.

In 1996, an independent evaluation of the Forum was undertaken. The findings showed that the Forum was a useful tool for coordinating project development and pooling resources, however greater role clarity, accountability, adequate resources and an effective reporting mechanism was an area that needed improvement (FHF 2002).

In 2002, an evaluation of the Forum was undertaken which surveyed members of the Forum using an evidence based checklist developed by the NSW Health. The findings indicated that the Forum possessed the capacity to identify health issues, to develop appropriate mechanisms to address them and to apply its resources to achieve shared health outcomes. The findings identified organisational structures of the Forum require the greatest attention, specifically: direction setting, reviewing progress and documenting outcomes with respondents unequivocally agreeing that performance targets needed to be set so that achievements could be measured and timelines set (FHF 2002).

In 2003, a review of the partnership model identified that there had been at least five different project workers employed since its inception. The lack of continuity was identified as a barrier on the level of achievement attained by the Forum. Decisions on expenditure over $500 were made at the Forum meetings, which demonstrate the power and control status and lack of trust of the partnership. Predominantly, the Forum provided opportunities for organisations to pull resources, to achieve shared priorities with members of the Forum being required to report on achievements (FHF, 2003).

According to O'Donnell (2012) and Riggs et al (2013), the Forum operated on the lower end of the continuum, primarily achieving networking through the exchange of information and coordination by altering activities to achieve a common purpose. The barriers to effective partnerships of funding, time, turf and trust (O'Donnell 2012; Norris-Tirrell Clay 2010; Martin-Misener and Valaitis 2008) appear to be evident at this early stage of the Partnerships maturity.

Over time, Health and FCC developed improved mechanisms to consult/communicate with local communities, and after an extensive review process in 2003, it was agreed to end the Forum and begin an entirely new partnership model. This new model focused on operations and planning between Fairfield Health Services and FCC and was called the Fairfield Partnership for Health (FHF 2003). The partnership continued during this period.

Episode 2 – The Fairfield Partnership for Health – Cooperation

In 2006, Fairfield Hospital, Community Health Services and FCC agreed to pilot a Partnership for Health model (P_4H), with NSW Health and FCC both contributing $30,000 per year to employ a part-time Community Project Officer, based at FCC for 21 hours per week and project costs. The first P_4H meeting was held on 6 April 2006.The pilot aimed to develop a model for partnership between LG and health which could be evaluated for replication in other areas (FHP 2007). During the pilot the P_4H consisted of two components:

- Develop, implement and evaluate the pilot model
- Develop and implement two key projects being physical activity and tobacco cessation.

A review of the P_4H was undertaken in 2007 (FHP 2007). The findings identified that the P_4H had achieved a great deal in terms of project based strategies, demonstrating that LG and health can work effectively together on joint initiatives, provided there is agreement on what sort of work is to be undertaken and clarifying what resources each agency should contribute. Partners agreed the model was able to facilitate a process of getting to know key personnel in each organisation and how to engage with them for mutually beneficial interests. Partners also recognised further opportunities that could be explored, particularly in terms of strategic long-term planning. The review identified a number of challenges for the P_4H which included the complexity of health structure in discussing issues which were responsibility of a different health division and considering area wide versus local service initiative. There was some confusion over expectations and discrepancies amongst the group due to the objectives being unclear. There was also dilemma over differences of opinion and the P_4H role in relation to local advocacy and whether this was appropriate for the partnership. There were also differences of opinion relating to decision-making processes and whether all partners felt they had equal input. The review identified a number of elements for the P_4H moving forward:

- Trust and financial commitment – need to develop and build the relationship. Need to consider total funds required and be explicit about level of support.
- Shared decision-making – to ensure stronger shared governance, recommending that meeting be chaired by partners on a rotations basis.
- Commitment – there is clear commitment from senior management, however time is a barrier for senior staff, recommending that meetings should occur less frequently (quality over quantity).
- Members – due to priorities the Hospital withdrew from the Partnership, replaced by Population Health.
- Strategic – opportunity for joint planning and being more strategic in working together.

Between 2007 and 2010 the Partnership continued with priorities of: (FCC 2016):

- Strategic: joint planning; emerging trends and adding value to existing initiatives; and
- Projects: physical activity; tobacco and evaluation of the partnership.

In 2008, the P_4H identified eleven steps for partnerships though time and change as being: understand who is on the team and why; take time to discuss the needs of members; develop a model – who, what, how, why and when; establish a supportive framework; build in the budget; establish explicit rules; invest in people; understand political environment; be realistic about what can be achieved; take time to reflect; and seize opportunities (FHP 2009).

A further review occurred in 2009 found that the P_4H was assessed as worthwhile by almost all respondents. The review identifies three areas for improvement being: develop more explicit objectives; improve communication methods including project reporting; and greater involvement from Community Health. The review recommended the next phase of the P_4H have greater focus on strategic planning. In 2010, Community

Health withdrew from the P_4H, due to redistribution of priorities in NSW, with Health Promotion Unit taking their position (FHP 2009).

According to the literature (Riggs *et al* 2013:4), the P_4H during this period had matured to functioning in a cooperating: sharing resources for mutual benefit and to achieve a common purpose phase showing the progression of the FHP through functions of partnerships.

Episode 3 Fairfield Health Partnership – Collaboration and Mobilising

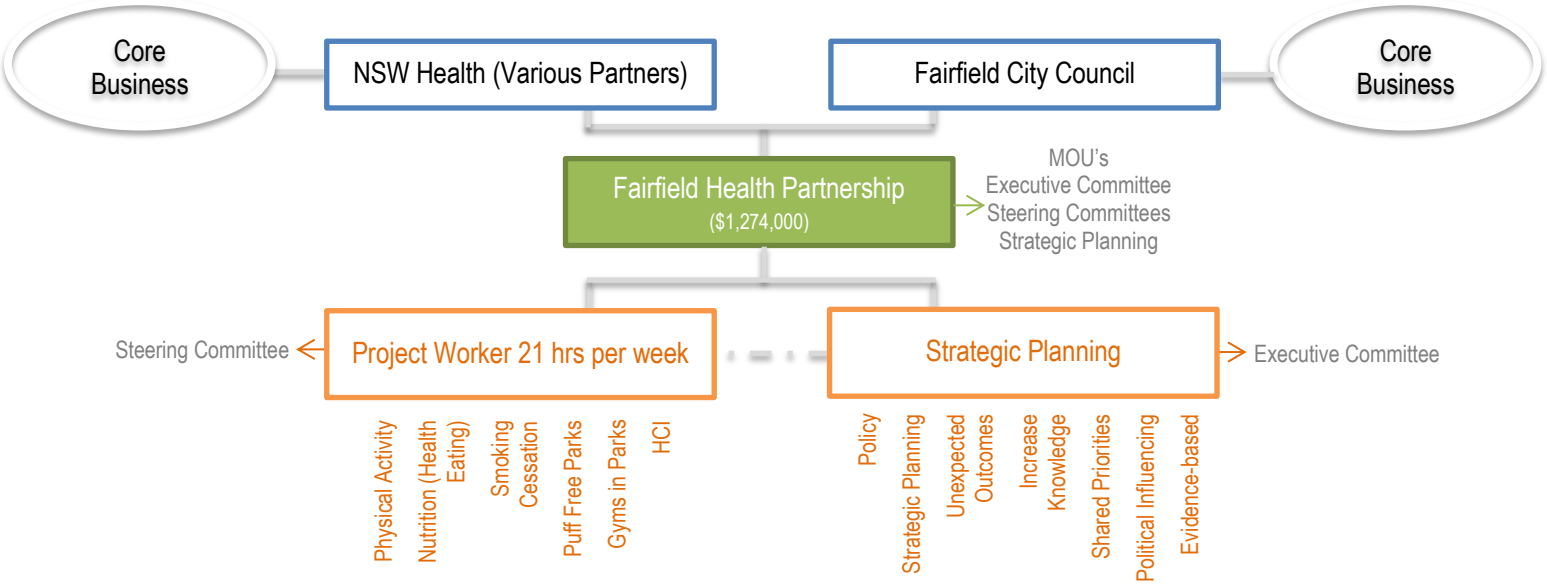
This period, continuing until the present, has seen the partners embrace a collaborating approach which has enhanced the capacity of another for mutual benefit and to achieve a common purpose (Riggs *et al* 2013:4) through to a transformational partnership which creates system-wide impact and creates capacity to reach scales and create lasting impact (UNGC; BSR 2012).

FHP has been governed by an Executive Committee consisting of senior staff and political representation, employing a joint project worker for 21 hours a week (FCC 2016). The priorities between 2010-2013 were:

- Strategic: collaborative initiatives; share information; trend analysis, add value.
- Projects: Health food environments; smoke-free environments; and physical activity.

Figure 12 describes the model of the FHP which was established in 2010 and continues today.

Figure 12 Model of the FHP – Inputs



As can be seen in Figure 12, the FHP, two organisations have come together to collaboratively achieve a common purpose through share resources.

The independently-conducted FHP evaluation (Aves 2011) focused on the process outcomes of the collaboration found that due to the continuity and commitment of the partnership, the FHP has delivered on its targets, offers a platform for debate about issue, where those involved in the FHP described having *'worked hard to reach this place of very robust relationship, were comfortable to challenge and there is a sense that now is the time to move things to a higher level'* (Aves 2011:2). The evaluation measured the FHP against the elements of effective partnership identifying, that the FHP had demonstrated that a significant presence of every element from the Partnerships Matters good indicator of effective partnerships (trust, power & relationship; leadership & strategy; purpose; action; roles and responsibilities; performance & learning; organisation and accountability; and

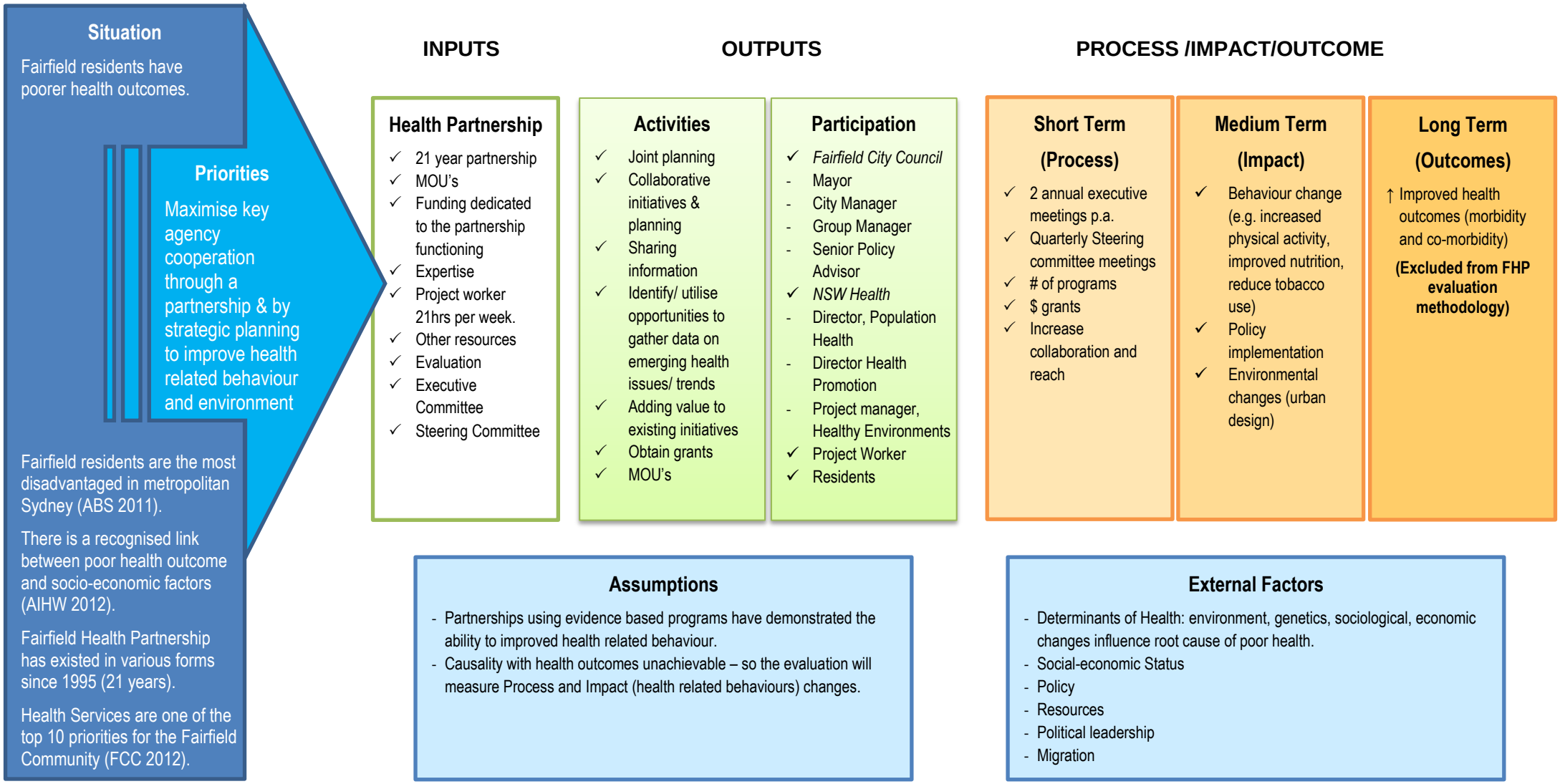
stakeholder involvement). The report found evidence to suggest that the FHP had reached a transformational partnership level, as both partners identified numerous ways that they had integrated and mainstreamed ideas developed in partnership "*the activities are glue while the real outcomes is influence and opportunity to change strategy'* (Aves 2001:2). The main challenge identified was to ensure the FHP remained relevant to the member organisations, targeting their strategic agendas so as to attract and retain commitment within an environment of uncertainty and change (FHP 2011).

The FHP's most recent Memorandum of Understanding (FCC 2016) 2014-17 identified the following aims and objectives:

- Develop and implement an integrated approach to addressing health in strategic planning, policy development and program delivery.
- Reduce smoking related harm.
- Support the development of environments to promote healthy eating and active living.

The findings from the audit showed the FHP growing in maturity from a partnership focused on networking and sharing information to one which has been described throughout the documentation as an impactful partnership which has created system-wide impact and created capacity to reach scales and create lasting impact. One feature of the FHP has been continual commitment to evaluating and evolving the FHP to meet changing needs.

Figure 13 Program Logic Model: Inputs and outputs of the FHP



Source FCC 2016

Evaluating the Fairfield Health Partnership

The effectiveness of FHP has been assessed across the decades, and these formal evaluations narrate the journey of the partnership as being one that has shifted from networking into a partnership characterised by collaborating and mobilisation functions. Much of the evaluation has focused on the structures and processes required to build the FHP and little attention being given to the impact of the partnership.

There is a lack of tangible evidence to support that HPs has any effect on health outcomes, (Hayes et al 2012). The reason for the lack of evidence is partly due to a number of challenges associated with the research environment. Firstly, empirical studies have failed to make any causal link between HPs and health outcomes (improved health or quality of life). It has been recognised that measurable outcomes need to be measured in the long term which may be difficult to attribute to the partnership. Secondly, it is difficult to assess the counterfactual, such as what might have transpired in the absence of the partnership (Dowling et al 2004).

The research paper examines the FHP and whether a shared vision, governance framework and agreed priorities influence the partnership's ability to achieve its objectives and influence health in the Fairfield LGA.

Due to the longevity of the FHP the research builds on the evidence of HPs beyond just assessing the characteristics of a successful partnership (process). According to the literature attributing causality will be challenging, however the opportunity to evaluate a partnership which has traversed two decades, provided a unique opportunity which is important to LG and health sectors.

The next chapter outlines the research design and methodology. The evaluation of the FHP uses a two-pronged approach which measures both the effectiveness of the partnership (process) as well as the influence it has had on health related behaviours (impact).

Chapter 5

Research Design and Methodology

Purpose

The research undertakes an ex post facto[5] evaluation of the FHP, which reviewed available information to reveal the possible relationships of the FHP with plausible cause-and-effects (Simon and Goes, 2013). The research used a two-pronged approach which measured both the effectiveness of the partnership (process) as well as inquiring about impacts on health related behaviours (impact) using both qualitative and quantitative analysis.

The research is important for the sector as the expectations on LG in relation to health continues to grow. Health is complex with many players responsible for interrelated elements, with HPs continuing to be 'on trend' as a way of improving health and wellbeing at the local level. The evaluation of the FHP enlightens LG and health sectors on how to work effectively together to improve health at a local level. A Partnership Capability Framework (PCF), informed by the literature and the FHP journey, which was further matured by the research, was developed. The Framework provides the LG sector with an instrument which sketchers the functions and capabilities required to develop effective partnerships. The research answered the following questions.

Research Questions

The research aims to evaluate the FHP and if working together enables collaborative advantage, whereby generating something greater than the sum of its parts, creating public value. While HPs are embedded into practice, the critical question for the FHP is about to what extent did the FHP has achieved better health outcomes. The primary and secondary research objectives of the research include:

1. Did working together achieve better health outcomes for the citizens of Fairfield, than if we didn't work together? Did working together make a difference?
    a. What are the characteristics of an effective partnership in health prevention?
    b. What, if any, were the unintended consequences of working together?
    c. Did the FHP make any difference to the health of Fairfield residents in relation to health related risk behaviours?

Tools for evaluating of Partnerships

There is a plethora of tools to assess the effectiveness of partnerships which provide guidance for the evaluation of the FHP. The following partnership tools have been reviewed and customised to inform the methodology.

The Wilder Foundation's Collaboration Factors Inventory assess collaboration is doing on 20 research-tested success factors, that identifies the level of agreement with a series of 42 questions (Wilder Foundation).

The Centre for Disease Control and Prevention's Partnership Evaluation Guidebook provides a step by step guide to evaluating HPs, clarifying approaches to methods of evaluation. The Guide provides several examples and tools which are applied to case studies to demonstrate applicability. The Guide primarily focuses on a survey methodology to measure effectiveness (CDCP 2011).

The Centre for the Advancement of Collaborative Strategies in Health's Partnership Self-Assessment Tool assesses how well its partnership process is working and identifies areas for improvement. The Partnership Self-Assessment Tool was developed (Lasker et al 2001) to provide a measurement of the key indicators for successful collaboration and level of synergy. The Tool consists of 67 questions covering 11 topics using a Likert scale and/or yes and no questions. Topics include synergy; leadership; efficiency; administration and management; on-financial resources; financial and other capital resources; decision making; benefits of

[5] Ex post means 'what is done afterwards' and is ideal for conducting social research when manipulating the characteristics of human participants is not possible (Simon and Goes 2013).

participation; drawbacks of participation; benefits and drawbacks of participating in the partnership; and satisfaction with participation. The tool was evaluated for validity and reliability (CACSH 2002).

The Canadian Coalition for Global Health Research's Partnership Assessment Toolkit is an evidenced based Tool composed of a series of questions to measure HPs through four stages: Inception, Implementation, Dissemination and "Good endings and new beginnings" (Afsana et al 2009).

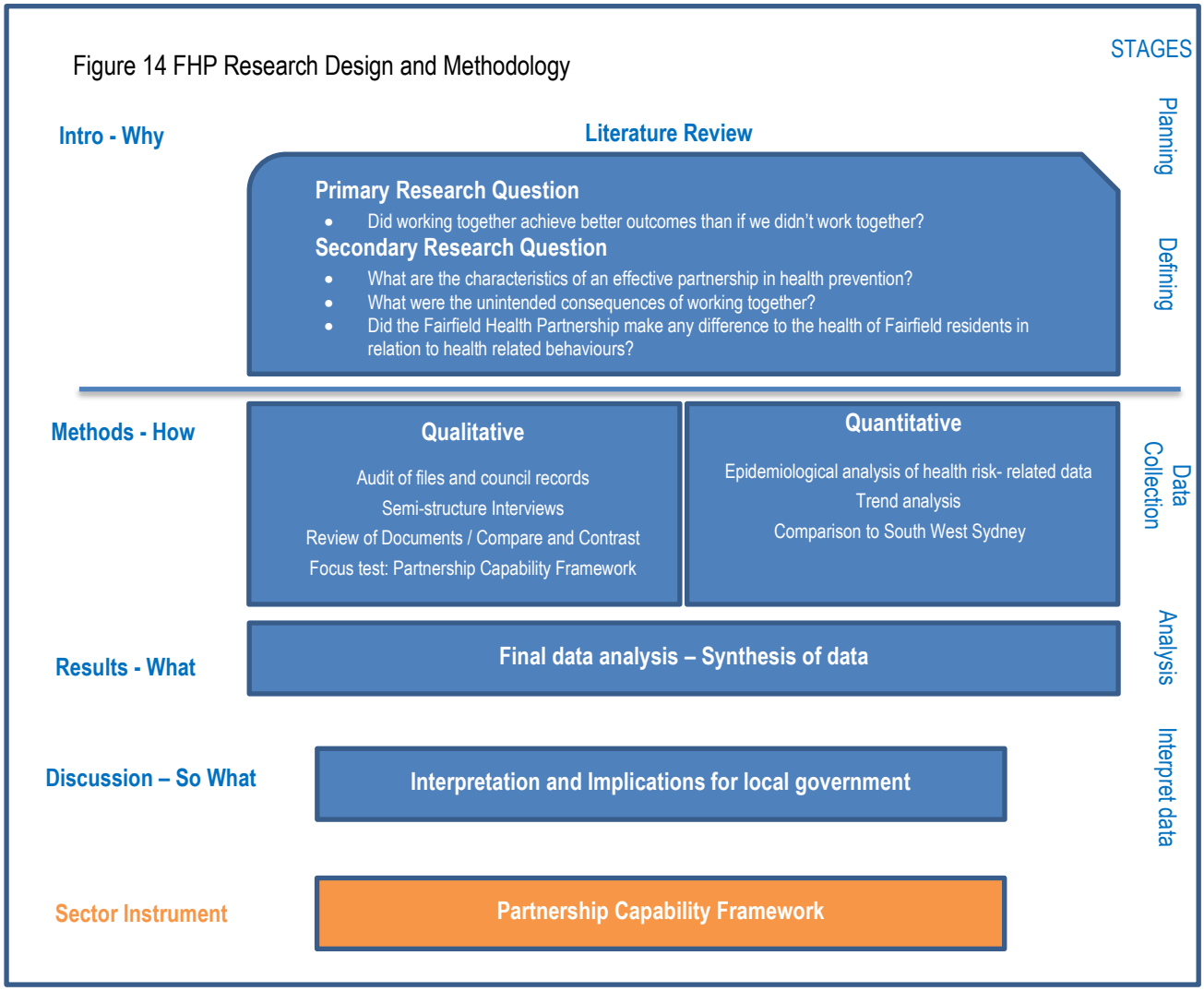
The Verona Benchmark is a management tool that has being piloted in 15 sites across Europe which measures the effectiveness and the quality of partnerships. The Tool uses a series of self-assessment questions covering 11 elements aimed to assess the strengths and areas for improvement in a partnership (Watson et al 2000).

The tools identified in the literature adopted a questionnaire methodology. The evaluation of the FHP undertook semi-structured interviews to obtain in-depth understanding of complex issues. To provide more rigger to the evaluation of the FHP, interviews were guided by the tools for evaluating effectiveness of partnerships.

Research Design and Methodology

The mix-method research design is described in Figure 14.

Figure 14 FHP Research Design and Methodology



The methodology is described in further detail below.

Method, Sampling and Data Gather

Qualitative Analysis

The semi-structured interviews were undertaken with six recent members of the FHP to gain an in-depth understanding. Research with members of the FHP, during episodes 1 and 2 were already available through previous evaluation reports. Interviews were undertaken with both NSW Health and FCC and across multiple levels.

Interviews were undertaken in person or via the telephone and were recorded for analysis. Participation was voluntary and responses were de-identified to protect privacy. The following guide outlines the questions asked during the semi-structured interviews.

PART 1A: Process: Elements of successful partnerships

1. Has the FHP achieved its objectives? Has the partnership been successful?
2. What factors (both positive and negative) have impacted on the FHP?
3. In what way have you eliminated barriers and unresolved conflicts that made progress difficult?
4. The partnership has been running for 21 years – why and what's the secret to its longevity?

PART 1B: Process: Partnership Capability Framework

1. Literature describes the highest function of effective partnership is transformational, where organisations make themselves vulnerable to the influences of partners. Where does the FHP sit on the continuum? (Networking, Philanthropic, Coordinating, Cooperating, Collaborating, and Mobilising). Can you give any examples?
2. Participants were asked, on a 10 point numerical response slider scale, to rate the importance and satisfaction of each of the nine elements of effective partnerships, identified in the literature. For each element participants were asked to identify the following:
    - How important is (*Insert Element*) in achieving a successful partnership on a scale of 1 to 10, where 1 is not at all important and 10 is extremely important?
    - Thinking about the Fairfield HP, how effective and satisfied (Insert Element) do you think the Fairfield HP is/was?
    - Why would you say that? What worked well and what didn't?
3. We have now rated a series of elements which the evidence highlights as important factors of HPs. Are there any characteristics of effective HPs which you would like to add?
4. The Partnership Capability Framework has been developed based on the literature and audit of the FHP journey. Does it reflect the elements and functions of effective partnerships and what comments would you make?

PART 3: Impact

1. What happened or changed as a result of the partnership?
2. Have there been changes in practice or services provision as a result of the partnership?
3. What unanticipated positive or negative impacts / outcomes have arisen from the FHP?
4. Describe two things that have contributed to the success/failure of the partnership?

The results are presented in Chapter 6.

Quantitative Analysis

The purpose was to explore retrospective epidemiological health data to measure the effectiveness of the FHP by analysing available datasets to determine any changes to health risk behaviours in comparison to other neighbouring multicultural disadvantaged areas. The research used a triangulation design to increase the validity and interplay overtime between different associated sequential data sources.

The first component conducted a secondary analysis of qualitative datasets. Pre-existing datasets were interrogated to identify government data sets which disaggregated to the LG geographical level and datasets which provided data on predetermined health risk behaviours variables from 1994 to 2016. Data sources were selected to ensure they were from a reliable source, for validity.

The following datasets were reviewed for available data at a local level in the areas of physical activity, smoking cessation and nutrition. A limitation for the project has been the inconsistent data sets over the life of the project and the availability of LGA data, so a non-linear research approach was adopted to pull together divergent information.

- Australian Bureau of Statistics
- Australian Institute of Health and Welfare
- NSW Adult Population Surveys
- Social Health Atlas: NSW Population Health Survey
- Medical Locals (Previous Fairfield Divisions of General Practice)
- Fairfield City Council: Satisfaction and importance source data (CATI surveys 95% confidence level)

The second component presents a series of Case Studies to help interpret predominantly qualitative findings in parallel to cross validate and build on results. The chosen Case Studies present an account of inputs and outputs across the FHP priority areas.

The challenge for the research was demonstrating causation. Causation can only be confidently assumed when there is a clear pattern across the datasets and case studies and other potential causes have been excluded. Analysis of epidemiological data and trend comparisons to determine any changes to health risk behaviours was undertaken, juxtaposed to another LGA with relative somewhat similar epidemiological characteristics. Causation was made even more difficult due to Fairfield LGAs unique characteristics, which as outline in the evidence, means that Fairfield residents are more likely to have poorer health behaviours, as outlined in Chapter 3.

Potential Bias

The ex post facto study is supported by observational methods as the researcher was a member of the partnership. The researcher originally worked for NSW Health and attended the FHP meetings as an active observer from 1997 until 2003 and later as a member of the partnership as an employee of FCC from 2007 until present. Involvement by the researcher in the FHP had both advantages and disadvantages, in that it provided a unique opportunity to reflect on the journey while also has the potential to create a bias due to lack of independence. The methodology was designed to minimise any bias and ensure an accurate account.

Chapters 6 and 7 provide an account of the findings of the evaluation.

Chapter 6

Presentation and Analysis of Findings - Qualitative data

Partnerships take time, commitment, resources, regular reflection and provide opportunities for two parties who see different aspects of a problem to search for solutions that go beyond their own limitations. But what systems and processes are required to make a partnership work and what capabilities do members of the partnership need to possess to make it successful? The following provides an evaluation of the FHP and assesses it against the foundations of effective partnerships identified in the literature.

Findings

A series of six in-depth semi-structured interviews were undertaken with recent FHP members. The interviews provided insights into the complexity of the FHP. The analysis and reporting focus on three key areas (i) the success of the FHP partnership in fostering collaboration; (ii) the identification of enabling factors and (iii) if the FHP made a difference.

Overall, there was clear evidence that the FHP resulted in mutual capacity building over time and in some way influenced the health behaviours of Fairfield residents. The identified barriers and enabling factors for effective partnerships are reported in the next sections.

Did the FHP achieve its objectives? Has the Partnership been successful?

The interviews demonstrated that productive and effective collaborative relationships had formed over time between members of the FHP however interviewees all identified the inherent difficulty in measuring changes to health behaviour at a population level and the obstacle of establishing causal relationship. Nevertheless all interviews considered that the FHP had been successful and achieved its objectives.

The FHP over the decades had a two primary objectives comprising (i) to establish a partnership model for LG and health and (ii) to improve the health behaviours of residents.

> *"I think it has, our expectations have changed over time – we are working towards our strategic goals and we have had some wins"* (SWSLDH2)

The findings identified that the FHP had achieved a great deal in terms of project based strategies, attracting additional resources and influencing agendas beyond the realms of the partnership, demonstrating that LG and health can work effectively together on joint initiatives. Aves (2001) described the projects as the glue, while the real outcomes came from the opportunity to influence and change policy. This theme emerged again throughout the research, with participants identifying that the FHP was not only an efficient way to check off milestones, but was most effectual in changing policy, inspire strategic direction and long term influence and change (FCC1). The FHP has evolved beyond just delivering project to something that influence agendas and resulted in sustainable benefits.

> *"FHP has certainly been effective in getting health on the Council agenda" (*FCC1)
>
> *"Health service was trying to influence the Council more so than the other way around"* (SWSLDH1)

Interviewees identified that while the FHP met its objectives, it was the unintended outcomes that resulted in the biggest achievements. It was these unintended consequences where the real objectives were achieved, as without influences beyond the partnership, the partnership was simply an end to itself. The FPH was about influencing policy, strategic direction and ultimately ensuring that LG embraced its role in improving health.

> *"I believe it has been effective, while it has achieved through the milestones, it's the unintended that are the big achievements – the relationship as time when on – other things started happening" (FHP1)*

While there are limitations on measuring the impact of the FHP, interviewees all felt that the FHP had been successful in identifying the problem and putting actions into place to address the issues through embracing a

whole of government approach. While the FHP was a function partnership, it was the deliverables and strategic influences where the real outcomes were occurred.

> *"No doubt in my mind it's been successful, the FHP was a whole of government approach to community issues. We recognised our particular community have significant problems in specific areas – while we may not have solved the issues, the FHP has been successful – I think it would be a worse problem, had the FHP not been there" (FCC2)*

Most participants felt that the core objective was about two diverse organisations being able to show that they could work together and that it was essential that LG accept that they have a role in improving health. While improving health was a priority, it was identified that substantiating that the FHP made a difference to behaviours was always going to be challenging.

> "*I didn't expect it to improve the health of the people of Fairfield – it may or may not, but it's only a small contributor, so you wouldn't able to say with any certainty that it changed. The partnership works on Health promotion and public health things, what we work on take so long to bear fruit – it's never going to say it improved the health of people in Fairfield, it's not the goal* (SWSLHD1)

> "*Saw the Partnership as valuable in terms of a Partnership. It was essential that LG be involved in health issues – highly desirable/essential that health and LG authorities work together to a range of issue that affect the health of local residents* (SWSLHD1)

All interviewees considered that the FHP was successful as together it enabled collaborative advantage, whereby generating something greater than the sum of its parts, creating public value. The FHP not only created a successful partnership model, it also had successes in delivering joint projects, attracted additional resources, but most importantly it influenced both partner organisations policies, practices and strategic directions. The FHP was also identified as an enabler for the LG sectors involvement in health issues, as it facilitated other councils interest and adoption of health initiatives. All identified that the FHP provided a model of how health and LG can work effectively together, showing that the FHP had influences beyond its anticipated intentions, which has resulted in sustainable consequences on both organisations involved in the partnership.

The FHP has been running for 21 year – why and what's the secret to its longevity?

> *"Don't think the original people who established the partnership, ever thought that this thing, would last two decades – 21 years is huge"* (FHP2)

There was an acceptance by all partners that the longevity of the partnership goes beyond anything they could imagine. There were many ingredients identified to the secret of its longevity including:

Time was seen as critical in establishing the relationship.

> *"Takes a long time to build a really good partnership, the FHP gave themselves that time. Commitment to time was critical"* (FHP2)

Reinventing itself and progressively reviewing its purpose and membership was identified as essential to ensure return on investment.

> *"It (FHP) changes and is responsive to what's needed – it's constantly evaluated. It's about return on investment"* (FCC1)

Commitment and having the right people was seen as an essential ingredient.

"Health having the right people – having people who were committed to what we were trying to do. Commitment from top – it actually delivers – proves it has value – relationship with people who would not ordinarily work together – they are not natural bed fellows" (FHP2)

"Having the high level of involvement, having the Mayor, City Manager and senior people in Health has been critical, without that it wouldn't have lasted and we wouldn't have achieved the strategic things it has achieved" (SWSLDH2)

"We've got this, now 20 year relationship and we are serious about this……. A soufflé never rises twice! If anyone ever said that let's not do anything on the partnership for a year – that would have killed it – you have to keep the momentum going. It influenced me a lot – I was always keen to keep it going – a trial separation would have killed to partnership (SWSLHD1)

Communication and leadership were also identifies as vital, including the ability to have difficult conversations.

"If one party was unhappy they said so. Established different avenues to have the conversation, so that things could be raised in a non-confrontational way" (FCC1)

"Underpinning everything, I think, there has been a real belief by the people involved – in what the partnership was all about – I really do – there was a genuine concern to recognise the issues and do something about them – a real belief that like-minded agencies working together – could achieve something worthwhile in the community. Real genuineness by all parties, back up by relative modest amount of money and resources. Really good support staff from both sides – genuine committed effort. Resulted us in doing things that are both within and outside core business" (FCC2)

"*People ask: Why don't you do what you do in Fairfield everywhere, everywhere isn't Fairfield and everywhere doesn't have the Fairfield players, we didn't have resources to do what we do in Fairfield everywhere" (SWSLDH1)*

The FHP was a case example for Health to demonstrate how to work with LG which influenced other Council's agendas.

"It's exemplar a beacon of councils and LHD working together – there the terms in which I evaluated the partnership and it performance" (SWSLHD1).

"People who have been involved, had a commitment to it. Having outcomes that are 'poster' you can tangibly talk to people about it and talk about benefits of the project and make the case for reinvestment" (SWSLDH2)

The longevity of the partnership was a result of time, commitment, communication and leadership and the ability to reinvent itself and continue to be relevant, ultimately the FHP got things done and provided a return on investment.

"Need something happening – without something happening people get frustrated and walk away, we have had successes, have celebrated the small achievements" (SWSLHD1)

"You would think that at some point someone would say we can do this on our own we have learnt how to do it – but It's more than a project" (FHP2)

What has changed as a result of the FHP? Have there been changes to practice or service provision as a result of the partnership?

All partners identified ways in which the FHP partnership influences services and practice from both within the partnership, but also beyond. However, what may have occurred in the absence of the partnership was identified as an unknown entity.

"I think we have evolved and done different things – whether we would have done those in the absence of the partnership, it's hard for me to say, because walking paths, other councils not involved in a partnership that are doing that stuff. I think lots of programs that wouldn't have been run without the partnership and more community involvement in various health and fitness programs and health education programs that wouldn't have happened. Has that changed the council? We have always been a council that has done that stuff, that's possibly why we went into the partnership anyway. Highlights the type of council we are – one that wants to work in partnerships" (FCC2)

"Too good an initiative to let it drop – the benefits are in the particular way we influence each other" (SWSLHD1).

While it is clear that partners have changed as a result of the FHP, it is impossible to determine what may have been in the absence of the partnership.

In what way have you eliminated barriers and unresolved conflicts that made progress difficult?

There were a number of 'turning points', which produced a shared vision for the partnership, providing clarity, structure and guidance. It appeared that each time the FHP undertook a comprehensive review, that it resurrected itself and took the partnership to a new level. It materialised, to eliminate barriers and resolve conflict was dependent on open and honest communication between partners, through having the ability to discuss difficult and divergent views.

"Able to have awkward, difficult conversations, if you don't have them it doesn't work" (FHP2)

"Not an easy ride – willingness to do the hard work, discuss the sticky stuff" (SWSLDH1)

"Have to talk about issues that are sensitive to one party or another – upfront, talk openly – resolution of the issue – ok to not agree on an issue – but need to find a way forward - can't go forward if there is an elephant in the room" (FCC2)

"*When Mayor took over – conscious that he wasn't too keen on it – don't know what you did, but with a few months he seems to be a strong supporter –significant threat to the partnership continues to be a change to personal" (SWSLHD1)*

Examples of managing divergent views and practices arose from interviews. FCC made a decision to cease its immunisation program to the dissatisfaction of Health. At a FHP meeting, parties openly presented their rationale with robust healthy debate, where partners 'agreed to disagree'. Partners establish a working meeting to ensure the smooth transition of services, so as to minimise the impact on residents. Despite the difference, both parties worked together in a respectful and constructive manner to identify a way forward.

"Health were unhappy with Councils decision to cease immunisation, they told us. We were deliberately helpful and we were honest, they sometimes cut programs, partners were constructive, generous and respectful" (FCC1)

The interviews identified the differences between the two organisations. It was important for the success of the partnership to appreciate the divergent cultures and practices of each other and to allow partners to open themselves up to new opportunities and learnings. Health was described as having a long-term outlook while LG was painted as being political and agile in its approach. There was a need to meet and understand both approaches if the FHP was going to succeed, to obtain a balance between effective planning and achieving outcomes on the ground.

"Organisations worked differently – LG was very responsible to politics' agendas while health may spend years developing a project, LG doesn't have that time" (FHP2)

The interviews identified divergent paradigms, in relation to what constitutes evidence, describing Health's criticism about the use of local survey data. Health preferred population health data which originates every four years, providing a lag indictor. The results of a local survey showed an increase in teenage smoking rates for girls, the data was not recognised by Health however the next release of population health data mirrored the findings of the local data. At this time, there was an appreciation by Health that LG knows its community and that real-time data may prove somewhat useful (FHP2).

Conflict and divergent views create a dramatic shift in the partnership and are important factors in developing effective partnerships. The ability to communicate and discuss differences was critical components to building successful partnerships.

Functions of FHP

Participants acknowledge that the FHP continued to operate at the highest function of partnership that is mobilising or transformational. The interviews all identified ways in which the partnership had influenced their organisation beyond the partnership. It was acknowledged that the FHP operated on a variety of levels with the executive fostering a mobilising culture, with the elements of successful partnerships needed constant focus, to enable the FHP to continue to operate at that level.

> *"High functioning but needed constant maintenance"* (FCC1)

In some elements the FHP was operating at a mobilising level, however for a number of functions the FHP were identified as operating at a cooperating and collaborative function. The PCF added a level of complexity and allowed an assessment, across a matrix, to determine the heights that partnerships were reaching – allowing for partners to reflect on what is working and how they can improve.

> *"I think it's operating between a cooperating and collaborating level – as project worker, focused on delivering projects might be the executive have more of a strategic influences"* (FHP1)
>
> *"Shared resources – cooperating and collaborating – its variable – collaborating with a bit of straying into mobilising. Some are mobilising and pushing in that direction"* (SWSLDH1)
>
> *"Certainly at the mobilising end of the spectrum- it also has had the opportunity and ability to influence policy across other LGA"* (SWSLDH2)

There was general agreement that the FHP operated at the higher functions along the continuum and that the FHP at time embraced a platform of a mobilising.

Characteristics of Effective Partnerships

Interviewees were asked to identify the key characteristics of effective partnerships, prior to considering the PCF. The results were uniform across the interviews and included:

Relationship, leadership, shared agenda and commitments were identified as essential ingredients of successful partnerships. Goodwill and generosity was a theme that emerged throughout the interviews.

> *"Goodwill and generosity" (FCC1)*
>
> *"Shared vision – if you haven't got a shared agenda it won't survive – if you haven't got that it's not a partnership it's a … power control relationship"* (SWSLHD1)
>
> *"Come down to goals and objectives – power and control don't matter if there is shared agenda. It comes down to the people and their commitment" (SWSLHD2)*

"Identified outcomes that you want – clear on the need for the partnership – commitment – equality committed to putting in an equal effort, straight with each other – it's the time you take dealing with those issues. Don't over reach – limited resources – operate within your means. Limitations and expectations need to match resources – but optimise and maximise the resources you have" (FCC2)

Communication and trust were also identified as critical and that it was important that partners understand the paradigms in which they operate. More so, than just conversing, it was identified that understanding the language and cultures were essential elements.

"Shared language is critical – you need to be bilingual. At the start we were using the same words but they had different meanings to different partners" (FCC1)

"Trust, relationships, all partners having clarity about who is responsible for what, building a partnership that allows them to influence each other. Joint decision-making – meaningful input but also return on investment. Respect – that's not automatic, but fundamental to good partnership practice. Accountability. Willingness to say it wasn't working – where to from here" (FHP1)

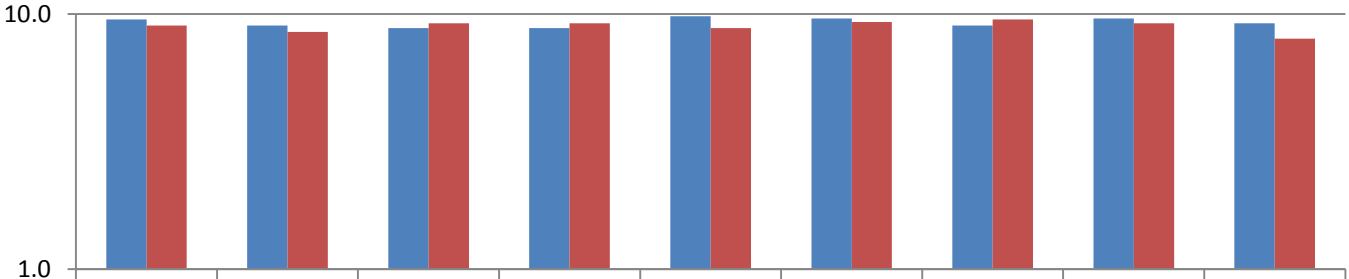
There is a complex web of crucial elements required to establish effective partnerships. The research of the FHP identifies numerous elements which are reflected in the literature. Interviewees were presented with the Framework and were asked a series of questions as outlined below.

Elements of effective partnership and satisfaction with FHP

Participants were asked, on a 10 point numerical response slider scale, to rate the importance and satisfaction of each of the nine elements of effective partnerships, where 1 was not at all important and 10 was extremely important.

As can be seen in Figure 15, the overall differentiation between importance and satisfaction was insignificant.

Figure 15 Average score for importance of effective partnership and satisfaction with the FHP



	Commitment	Power & Control	Relationship	Shared Resources	Shared Vision	Leadership	Trust	Communication	Evaluation
Importance	9.5	9.0	8.8	8.8	9.8	9.6	9.0	9.6	9.2
Satifaction	9.0	8.5	9.2	9.2	8.8	9.3	9.5	9.2	8.0

Figure 15, that FHP encompassed all the elements required to establish effective partnerships.

All the elements identified in the research were considered extremely important in establishing an effective partnership, rating of between 8.8 and 9.8 on importance scale. Shared Vision (9.8) was identified as the most important element to building effective partnerships followed by a Leadership (9.6), Communications (9.6) and Commitment (9.5). Power and Control and Trust were equally important scoring a ranking of 9.0. The least important elements identified were Shared Resources and Relationship both being rated 8.8, however a score of 8 shows that the element is still highly important to establishing effective partnerships.

The literature review (Chapter 3) identified in order of importance Shared Vision, Commitment, Trust, Power and Control, Communication, Shared Resources, Evaluation and Relationship and Leadership which was presented based on the number of times it was referenced in the literature.

The review of importance in comparison shows that while all elements were identified as extremely important, the priorities shifted positions of importance. The order of importance may vary however it is critical to the success of a partnership that the element exists and is agreed. The findings from the research reinforce the principle that for partnerships to be effective they require a complex web of elements to underpin its foundations, excluding elements will result in the partnership becoming less effective and less likely to survive.

FHP members were extremely satisfied will all elements of the partnership with Trust (9.5) and Leadership (9.3) being the highest rated elements, followed equally by Relationship (9.2), Shared Resources (9.2) and Communication (9.2). Partners were least satisfaction was with Evaluation (8.0) and Power and Control (8.5) however both were still rated highly satisfied by participants.

Trust, Relationship and Shard Resources, on average scored a higher satisfaction rating than importance. On all elements of effective partnership there was less than 0.5 ranking difference for all elements, except evaluation. Based on these finding, the FHP was a successful partnership which embraced all the elements required to build an effective partnership.

While commitment of the FHP across all levels was identified as essential, the drive and commitment of the project officers was identified as critical, by several interviewees. At the other end, political support was also seen as essential for successful partnerships. Carey & Crammond (2016) identified that HPs are most successful when supported at multiple levels and required political interest and visibility. However, the research found that while political support was essential, visibility was depended on the level of investment and how much attention that attracts.

> "*Apart from the Mayor – there was little knowledge of the FHP by rest of the Council – resources from their perspective are insignificant so hasn't been on the radar – if all of a sudden we want 200K we might test political resolve on it – I am sure there would be political support – but where that would be on the financial spectrum I am not sure"* (FCC2)
>
> *"Project Officer's commitment is critical to the success of the partnership"* (FHP1)

Relationship between partners was identified by all interviewees as effective and a key ingredient into the longevity of the FHP, receiving a higher satisfaction rating than importance. However, results on the importance were mixed with three interviewees identifying it as extremely important (10), while others considered it was important, but not critical. Relationship at all levels was recognised as important from the front line staff to executive, with relationships at different levels cascading throughout the FHP. All respondent felt that 'the people' and 'liking each other' was critical to the partnerships success.

> *"At executive level – commitment to meet 2 x a year – that there were things meaningful on the agenda and allowed them to build their own relationship – those meetings were not so much about them building relationships, as that grew you could see them shared sensitive information. Trust each other, head up on what was coming – I think the executives valued that"* (FHP1)
>
> *"We genuinely have to like each other"* (SWSLHD1)
>
> *"Dating then you get married – treat it like a marriage and if you don't you will get divorced. Good high functioning partnership needs constant maintenance"* (FCC1)

Power and Control at a commensurate level was identified as important, however being equal on everything was found to be unrealistic. What was identified as important was that, the balance of influence needs to demonstrate

that the partners considered that they were receiving return on investment and that they were able to influence the agenda. It was identified that, as the FHP had a shared vision, the importance of power and control reduced.

> *"Could image a partnership may work, you might tolerate being a junior partner if you were getting something out of it"* (SWSLHD1)
>
> *"We have equal power but different types of power – equal power but in different areas and capacity of power, they have more ability to influence our agenda we have more influence of projects at times"* (FCC1)
>
> *"Always room to improve, not sure we have been equal for everything, all of the time"* (FHP2)

Shared Resources was also seen as important for successful partnership (8.8), with FHP members extremely satisfied (9.2) with the level of resource sharing. The interviews showed that while the agreements aimed to ensure equal resources, in practice this is difficult and needed to be fluid. The FHP did not always have an equal Sharing of Resources. What was more important was a return on investment and those partners were prepared to contribute for the appropriate initiates. The Sharing of Resources was more important in determining who has the Power and Control and becomes more important when the partnership become dysfunctional.

> *Not always an equal sharing of resources – it's more like agreed – people contribute different things – it's important"* (SWSLDH1)
>
> "*Council was pumping in a lot more $ initially – in terms of cash"* (FHP2)
>
> *"If one person controls all the resources, they have all the power and control, so it's not a partnership – it comes down to return on investment"* (FCC1)

There was a high level of satisfaction with the Trust of the FHP this was highlighted s significance throughout all levels of the partnership from the front line to the executive. The FHP had a high satisfaction rating than importance with all interviewees identifying an extreme satisfaction with the FHP. Notwithstanding, the scale of importance received mixed responses with four participants rating it as extremely important (10) and the two Health participants rating trust as only important (7).

> "*When Council is doing it plans, they all have an undertone of health. Everyday it makes a different to people's lives and I think it stupendous that Fairfield has over 100Km of cycleway – the partnership and those communications has enabled those senior people to better understand, the things council can do, within it remit to improve the health if its residents"* (SWSLHD1).
>
> *"Even when we had different opinions we still had trust"* (FCC2)
>
> *"It's important that people are in the room when decisions are made, because without that you lose trust and lose everything. Good will – that might be trust – shouldn't get into a partnership with people you don't trust"* (FCC1)
>
> *"I think this has happened at a number of levels. Front line staff adept at unpacking what the issues were and what it was we weren't agreeing on – Health comes from position as being experts, sometimes that culture breeds superiority and they don't think anyone else is capable – time invested in relationship at front line were critical – if we couldn't work together no way we were going to convince the executive to do anything"* (FHP2)

Evaluation (8.0) was identified as the least satisfied element of the FHP. What was identified was that Achievement and Accountability were essential to the success of a partnership in which Evaluation was a tool to demonstrate how this was attained. Without Achievement and Accountability the longevity of a partnership would be at risk. Evaluation was seen as crucial in providing this accountability and determining public value, however evaluation on its own was lower in importance and satisfaction.

"We did do lots of evaluations – always room to improve" (FCC2)

"Always do better when you evaluate things" (FHP1)

"To be honest you could get away with partnership that doesn't evaluate – I personally wouldn't approve of it – but not that essential. Could have done it a bit better – can always do things a bit better" (SWSLHD1)

Participants were asked if there were any other elements omitted from the PCF. All felt the PCF provided a good representation of the characteristics required to establishing effective partnerships. Several interviewees felt more focus needed to be given to what the FHP was trying to achieve, the public value, and that the partnership actually did something. The focus on public value and achievement needed to be more strongly represented in the Framework.

"Identification – reason for the partnership reason for its existence" (FCC2)

"Got to do something, that more important than evaluating it…. If all you do is meet and have visions and like each other it's all very nice – it doesn't achieve much and eventually people get frustrated with that sort of thing. Down the left, achieving, active achieving and changing things is a higher in importance than evaluation" (SWSLHD1)

In summary, the findings demonstrated that it was the interconnected between elements that are important. Underpinning partnerships are a suite or complement of elements, missing one will lead to an ineffective partnerships. Through the evaluation of the FHP, the PCF was adapted to better reflect the need for public value through achievement and accountability, with evaluation converted to a tool within the Framework. The following Chapter presents a PCF which will inform the LG sector on the elements and factors required to developed effective partnerships.

Unintended Consequences of the FHP

One of the key identified success indicators of the FHP identified throughout the interviews were the inadvertent consequences. Interviewees were asked to list some of the unintentional upshots of the FHP. The principal identified outcome was 'knowing who to talk to' and 'knowing that they wanted to help'. Others included:

- Health Communities Initiative
- Health Impact Assessment for the Bonnyrigg Living Communities Project
- Health Urban Development Checklist
- The many steering committees
- Coordinated approach to Hoarding
- Advocacy Work – EP&A Acts Review, Mental Health, Gambling etc.
- Awards and Conference Presentations
- Reputation of both organisations
- Getting Health on the Council agenda

"Stamp out trouble with hoarding – We were able to get Mental Health services involved – The partnership just smoothed the introduction" (SWSLDH1)

"A million from the Commonwealth – Health Communities Initiative (FCC1) was a coup – Feds did not prioritise Fairfield as an area for funding, our health partners, who are connected at high levels advocated strongly for Fairfield" (FHP2)

"Outcomes – relationship and the type of work – council took on health initiates. 'Get Healthy at Work' – Council got support, health supported the Work Health and Safety team at council. 'Make Health

Normal' campaign – health contacted council to help promote in the LGA. Partnership gives you a way in (FHP1)

"With recent tobacco legislation – go directly to your contact at health – which went to NSW health – to develop resources in different language - FCC guide them in getting resources – FCC did translations which went NSW wide and Health paid for them" (FHP1)

"Smoking legislation – relationship with council, place managers and NSW health officers meet regularly on tobacco issues e.g. issue with smoking in specific areas e.g. restaurant down road allows smoking – they can talk and ask that they come out and have a look. Now just a phone call away. Open up communication" (FHP1)

"Where would we be without the partnership? Working on our own, challenges in seeking funding. Because we have a relationship with health – it gives us 'weight' when applying for grants. As Project Officer we have a relationship, it gives direction and then tailoring to Fairfield community" (FHP1)

"Everyone has heard about innovation at Fairfield and the FHP. Profile for council and health, to show that you can do things together inspires others across Sydney" (FHP2)

"*Puff Free Parks – open communication by resident to say we don't want people smoking around our kids – complaints to council – community felt empowered to speak up"* (FHP2)

The FHP has transformed partners and influenced agendas beyond the realms of the partnership, creating system-wide impact and creating capacity which reaches scales which create lasting impacts. Norris-Tirrell and Clay (2010) describe the requirement for managers and partners to think differently and work beyond disciplines and borders, this is evident in the FHP.

Limitations

Qualitative research is dependent on the skills of the research and the ability to minimise biases and idiosyncrasies. The challenge for this research was the small sample, which presented issues of anonymity and confidentiality. The researcher was known to participants, which may have also affected the subjects' responses. The challenge was maintaining confidentially while needing to minimise bias, subsequently verbatim quotes were included to reduce bias, while all care was taken to ensure respondents anonymity. One of the challenges of qualitative research is the volume of data however the findings of the research were significantly uniform, which increased the rigger and validity of the results.

Conclusion

The FHP is a successful partnership, with participants extremely satisfaction with all the elements required to build effective partnerships. All participants felt that the FHP had achieved its objectives and that working together enabled collaborative advantage, where by creating something greater than the sum of its parts, public value. FHP had successes in delivering joint projects, attracted additional resources, but most importantly it influenced both partner organisations policies, practices and strategic directions. The FHP was also identified as an enabler for the LG sectors involvement in health issues, as it facilitated other councils interest and adoption of health initiatives. At the same time, all acknowledge the difficulty in measuring any changes at a population level.

The PCF, presented in Chapter 9 was developed and then refined following the research. The Framework provides a sustainable methodology for joint planning and delivery of services across LG and Health which could then be replicated in other areas. The Framework provides a platform upon which to have the discussion and commence building partnerships.

Chapter 7

Presentation and Analysis of Findings – Quantitative Data & Case Studies

The following analyses the changes in population epidemiological data according to FHP priority areas of physical activity, smoking and nutrition to determine if the FHP made a difference to the risk taking behaviours. This chapter provides an assessment on whether the FHP had any influence on the resident's behaviours.

Physical Activity

Physical activity[6] has been identified in the literature as essential for health and wellbeing including reducing the risk of chronic disease and obesity (AIHW 2014). Physical inactivity is the fourth leading cause of death due to non-communicable disease worldwide and is the second greatest contributor, behind tobacco smoking, to the cancer burden in Australia (GHR 2009).

The National Physical Activity Guidelines which were established in 1999 sets a benchmark for sufficient physical activity as 150 minutes or more of moderate and/or vigorous activity per week over at least five days (AIHW 2014), nevertheless the way in which data is measured has changed over time. The Australian Health Survey 2011-12 showed that only 43% of Australian adults met the threshold, while adults in the least disadvantaged quintile were 1.5 more times likely to have done sufficient activity compared with those in the most disadvantaged quintile (ABS 2011-12). The prevalence of engaging in physical activity has been identified as being lower among females, older adults, people with lower socioeconomic status, people from CALD backgrounds and ATSI people (PCAL 2007).

The evidence on effective interventions to increase physical activity shows that little is known about the long-term outcomes of approaches such as information; behavioural; environmental and policy initiatives. Much of the literature reports short-term outcomes, with interventions that are multi-component and adapted to the local context, culturally and environmentally appropriate being the most successful. Little is known on the sustainability of intervention overtime, nor the cost-effectiveness of physical activity interventions due to the difficulty in attributing any change in a social environmental setting (WHO 2009).

Some evidence suggests that the built environment[7] is an important determinant of participation in physical activity. Walkable neighbourhoods[8] were found to be related to greater physical activity engagement compared with living in less walkable areas. Having access to community parks and facilities has also been found to have mixed associations with physical activity levels (Parker et al 2009).

The following case studies provide an insight into the activities of the FHP in relation to improving physical activity.

Case Study 1: Health Communities Initiative (HCI)

Through the National Partnership Agreement on Preventive Health the Australian Government provided $71.8 million over five years from 2009-10 to the HCI. HCI provided funding to LG to deliver effective community-based physical activity and healthy eating programs. Phase 1 provided $976,172 to 12 Pilot LGAs for the period April 2010–June 2013 which included FCC. Phase 2 funded 33 LGAs a total of $703,607 for the period June 2011–June 2014. Phase 3 saw a further 47 LGA funded $566,042 for the period December 2011– June 2014 (DoH 2016).

Through the FHP, FCC secured funding in the pilot stage, demonstrating the importance of the FHP to the sector, and one of the leaders in promoting health and wellbeing.

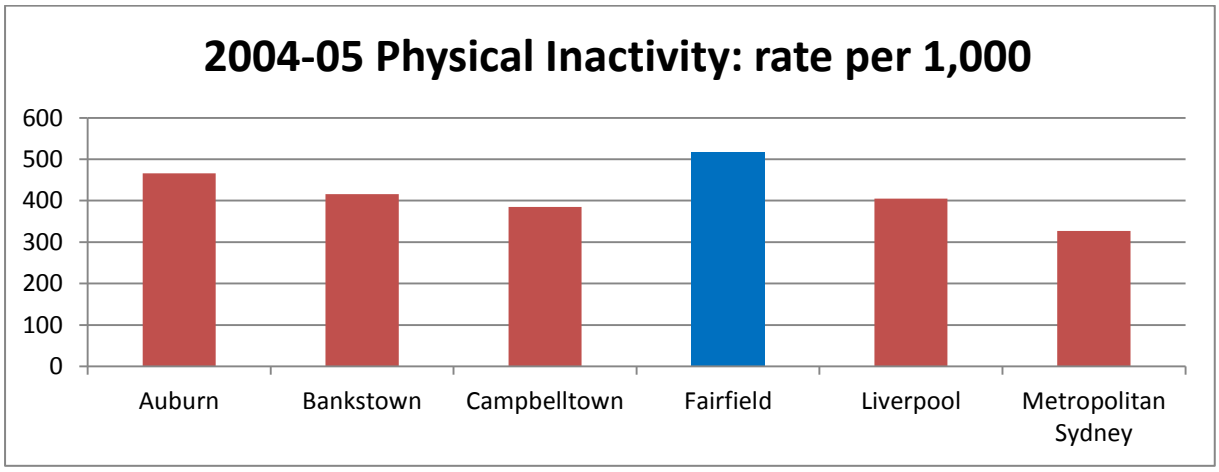
[6] *"Any bodily movement produced by skeletal muscles that requires energy expenditure and produces progressive health benefits"* (Sims et al 2006)

[7] Encompasses all the man-made elements including buildings, infrastructure such as walking and bike paths as well as functional use such as zoning, neighbourhood design and mix-used development (Parker et al 2009)

[8] high residential density, land use mix, street connectivity, better aesthetics and safety (Parker et al 2009)

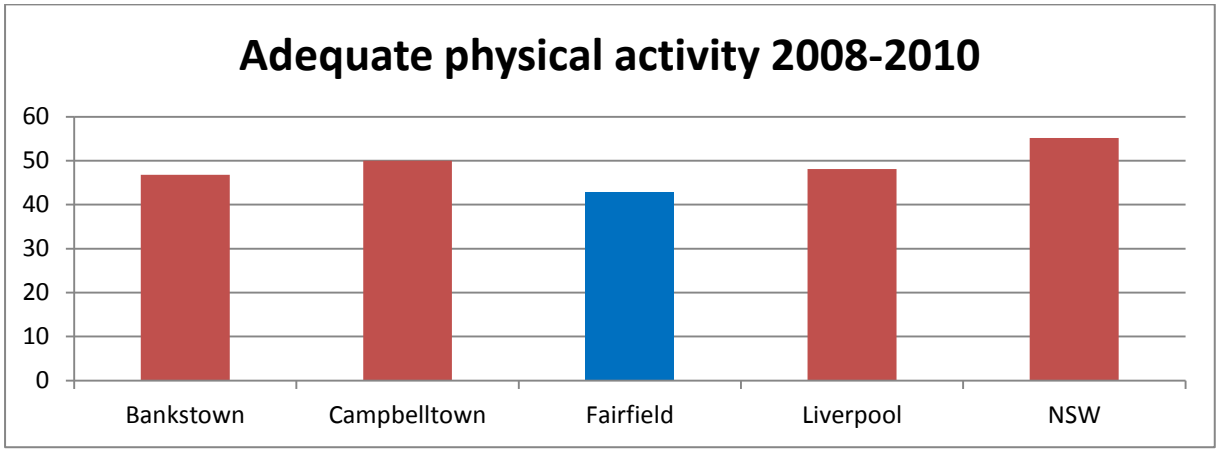
The following Figures show self-reported physical activity through the National Health Survey's (NHS). Physical inactivity was defined as those aged 15 years and over who did not exercise in the two weeks prior to interview for the 2004-05 NHS, through sport, recreation or fitness (including walking).

Figure 16 Physical inactivity, person aged 15 years and over comparisons (rate per 1,000)



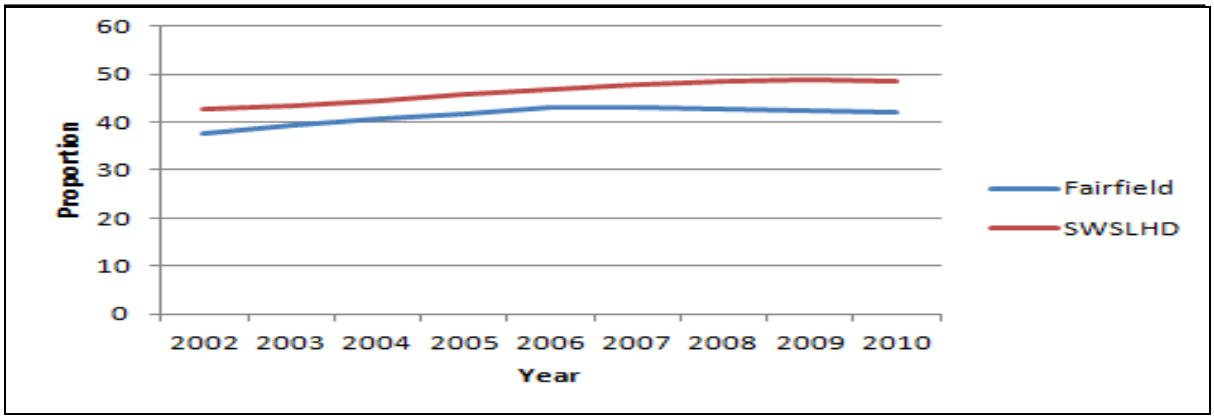
Source: PHIPU 2016

Figure 17 Adequate physical activities, persons aged 16 years and over 2008 - 2010



Source: SWSLHD 2014

Figure 18 Adequate physical activities, 2002-2010

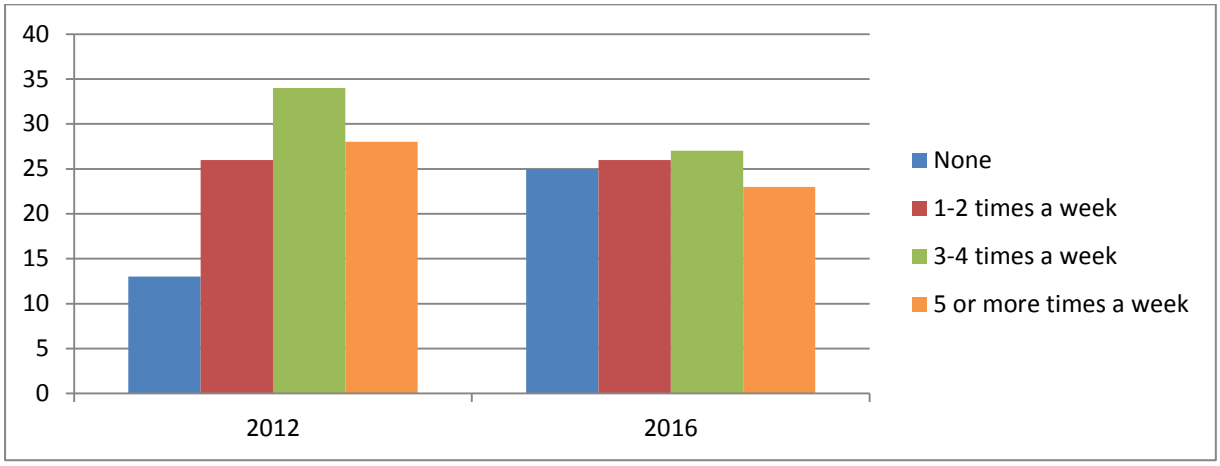


Source: Sainbury 2013

Notwithstanding the different data sources, Figures 16 and 17 shows that Fairfield residents have poor levels of physical activity than other metropolitan LGAs. However, participation rates as depicted in Figure 18 show that Fairfield LGA rates of physical activity have kept pass with other South West Sydney LGA between 2002 and 2010. Considering the level of disadvantaged and migration intake in Fairfield LGA, this is a positive result. Unfortunately, the Australian Government ceased to make local data available beyond 2010.

Due to this lack of available local data, FCC in 2012 and 2016 undertook a randomised survey of resident which provided reliable data at 95% confidence level (Micromex 2012 and Woolcott 2016). The self-reported survey measured how many times a week residents exercised for 30 minutes or more (N=600).

Figure 19 Weekly incidence of exercising for 30 minutes or more that makes you breather harder than normal 2012 and 2016



Source: Micromex 2012 and Woolcott 2016

Figure 19 shows a decrease in the number of residents participating in adequate physical activity, with the number of people undertaking no physical activity increasing from 13% in 2012 to 25% in 2016. The number of people undertaking adequate physical activity, that is 5 days or more increase slightly from 27% to 28%, from 2102 to 2016 respectively. Women and those who spoke a language other than English were less likely to be physical active (Micromex 2012 and Woolcott 2016). Unfortunately, comparisons with other LGA are not available due to the State Government ceasing to provide data at a LGA level.

Case Study 2 Health Built Environments

FCC has been committed to creating a healthy community through a commitment to building healthy urban environments and programs which assist the community in being active. A snapshot of the 2015-16 period demonstrates how health is integrated throughout FCC (FCC 2016).

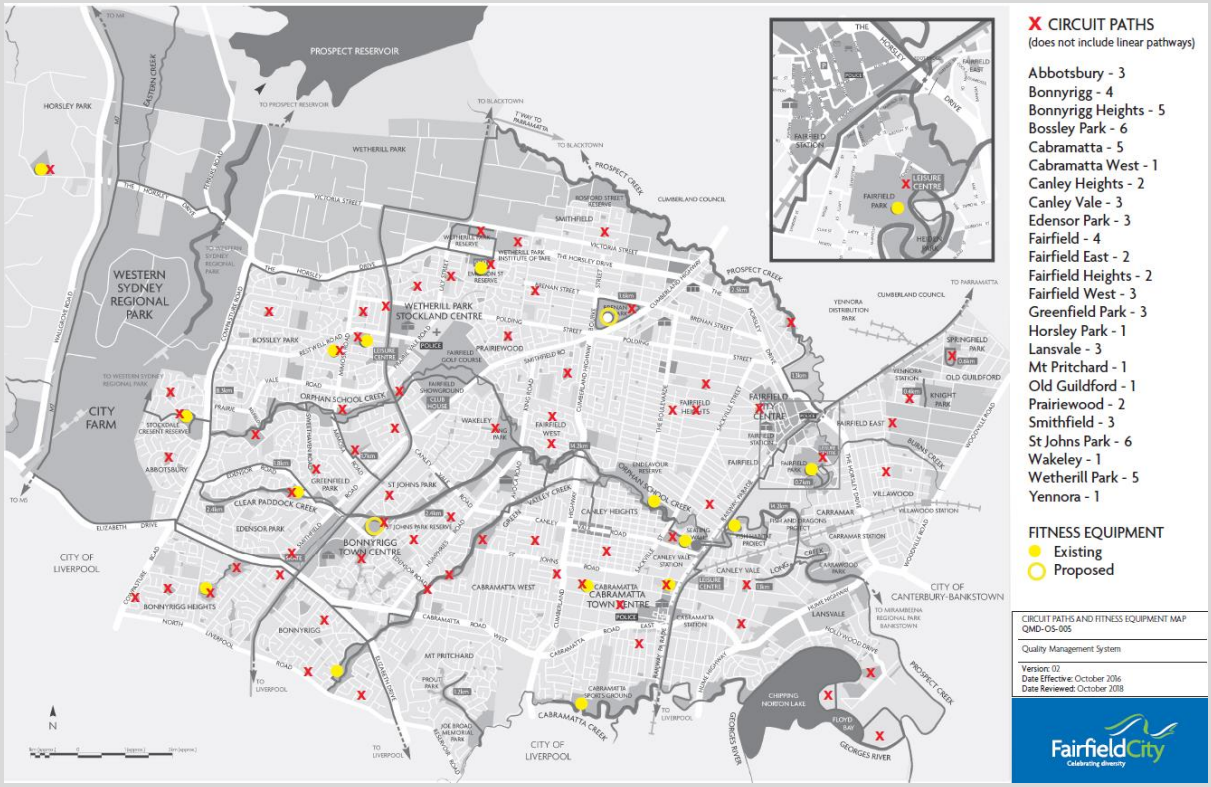
- In 2006, FCC established the Western Sydney Cycle Network (WSCN), which is run by volunteers with the support of Council, who repair and provided free bikes to the community, undertake community rides and promote local cycleway. In 2015/16, the WSCN had over 1,727 hours of time donated by volunteers to recycle over 250 bikes and held weekly bike rides which attracted on average 30 people.
- 100km of walking and cycling paths which was established through a 13 year special rate variation in 1988, which has continued today. In 2015-16 FCC completed over 2,394 metres of replacement footpaths across the city and installed 7,057 metres of new footpaths across the city.
- FCC has to also constructing circuit paths at its parks to increase walkability, in 2015-16 circuit walking path was constructed at Stockdale Reserve, Abbotsbury – see figure 20.
- FCC has also constructed gyms in parks to increase accessibility to those that can afford to attend the

leisure centres. FCC conducts free surprised gyms sessions for residents which were attended by more than attended by more than 80 people in Horsely Park, Emersen Street Reserve, Fairfield Park and Tarlington Reserve. See Figure 19 for gym locations.

- More than 1,198,336 people used Council's leisure centres. Fairfield Leisure Centre was extended to a 24 hours per day gym to increase accessibility. They ran the 12 week challenges twice with a total of 72 participants losing over 292.9kgs and delivered 140 bootcamp sessions.
- FCC hosted the joint South West Regional Councils food group meeting with six other Councils and the NSW Food Authority to discuss current food safety issues.
- A cookbook and stories of migration titled From Mestopotamia to Fairfield was developed in partnership with the Parents Café, a social enterprise based at Fairfield High School.
- The 2016 Seniors Week Fair had the opportunity to participate in healthy activities including line dancing, gentle zumba and tai chi.
- Fairfield Health Partnership came of age, reaching a 21 year milestone.

Figure 20 shows the infrastructure which supports health through heath urban design.

Figure 20 Circuit paths and fitness equipment locations



Source: FCC 2016

As can be seen by Figure 19 FCC has been committed to developing a healthy environment across the city.

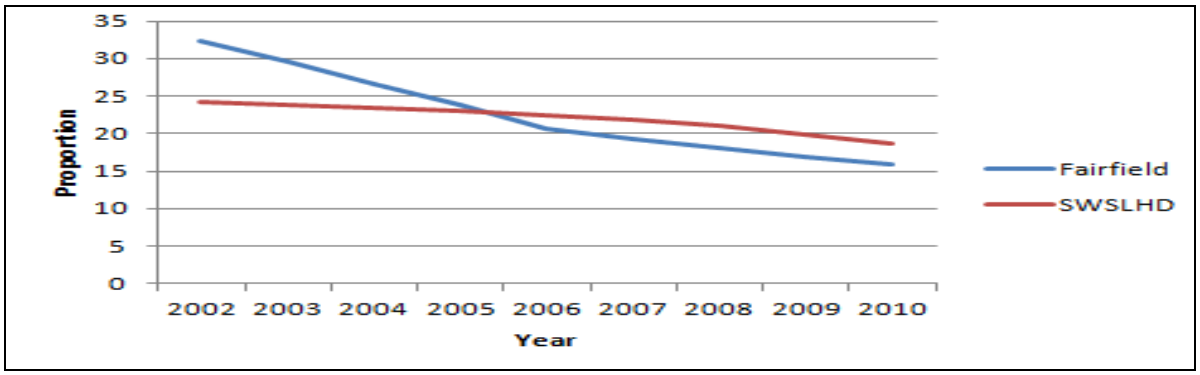
Fairfield LGA certainly has poorer physical activity participation rates than other South West Sydney areas. While differing data sources from 2002 to 2010 the gap between Fairfield LGA and other South West Sydney Council has narrowed. Without the FHP, one might draw a hypothesis that the gap may have increased however there is no reliable evidence to prove causation.

Tobacco Smoking

Smoking is the single most preventable cause of health and death in Australia. According to the guidelines, smoking tobacco on a daily basis is connected to various cancers, cardiovascular disease and type-2-diabetes (AIHW 2012). Tobacco use in Australia continues to decrease from 26% in 1990 to 22% in 2001 and 16% in 2011–12 (ABS 2011-12). Australia has adopted a range of intervention from stronger smoke-free laws, price increases, pharmacotherapy and mass media campaigns since 2004, having positive results in smoking prevalence (AIHW 2014). People living in the most disadvantage areas were more likely to smoke daily compared with those living in areas of advantage (23.0% compared with 9.9%). Males living in the most disadvantaged areas had a particularly high rate of smoking (27.4%) (ABS 2011-12). Daily smoking rates significantly improved among people living in the lowest and second-lowest socioeconomic areas, but not at the same rate as those living in the highest socioeconomic area (AIHW 2016).

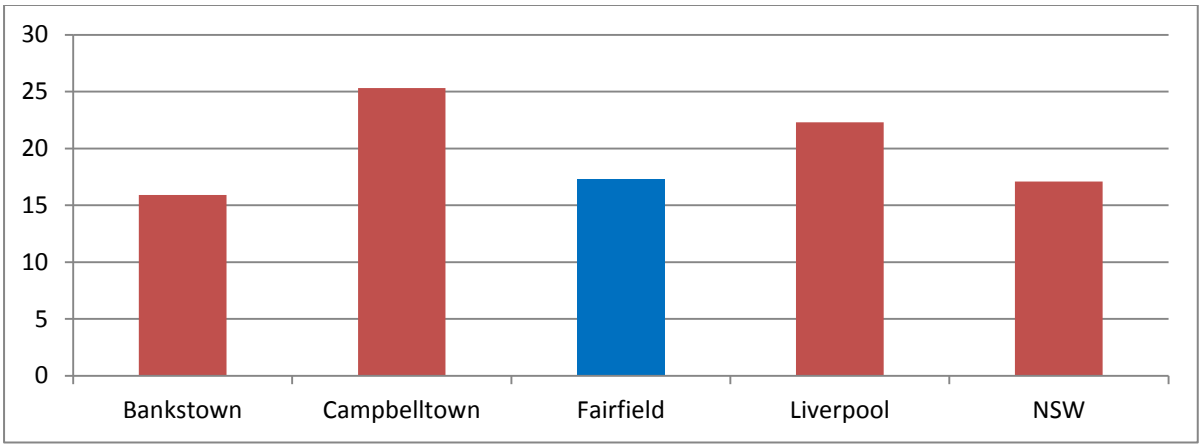
FHP has had smoking cessation and smoke-free environment as a priority since 2003. FHP has had a range of interventions from smoke-free environments (Case Study 3), mass media campaigns including world no tobacco day and interventions targeting high risk groups such as the Cabramatta Tobacco Project[9] which targeted smoking cessation with South-East-Asian communities.

Figure 21 Smoking rates 2002 -2010 Fairfield LGA in comparison to SWS Local Health District



Source: Sainbury 2013

Figure 22 Current Smoking rates 2008 -2010



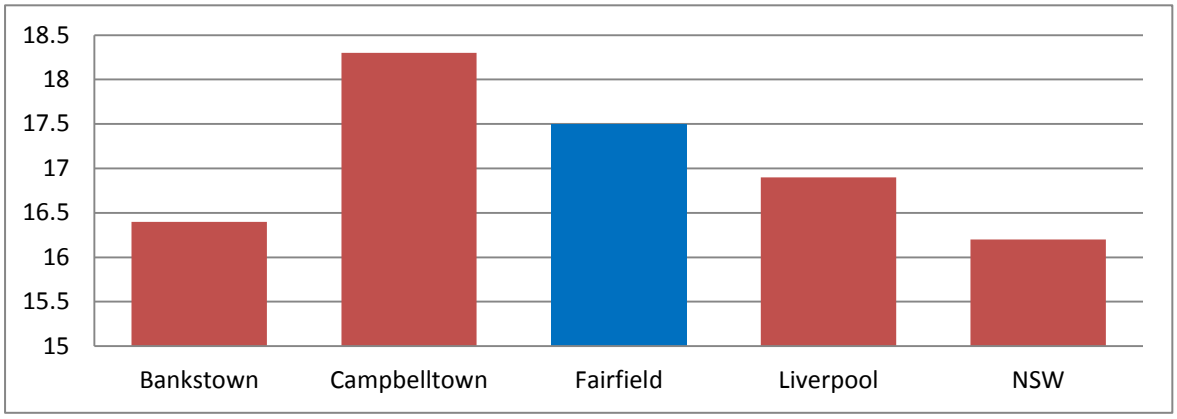
Source: SWSLHD 2014

[9] Cabramatta Tobacco Project – attracted a grant from NSW Cancer Institute targeting Culturally and Linguistically Diverse smokers in Cabramatta Town Centre

Figures 21 and 22 show that smoking rates in Fairfield LGA have decreased at a greater rate than other LGA in South West Sydney. This is surprising, considering the literature in relation to disadvantaged and migration.

Figure 22 provides LGA data for smoking rates from 2011-2013.

Figure 23 Smoking rate 2011-13



Source: PHIDU 2015

Figure 22 and 23, shows that smoking rates in Fairfield LGA have not continued to reduce at the same rate as other LGA, supporting the literature that daily smoking rates for the lowest and second-lowest socioeconomic areas, have not improved at the same rate as those living in the highest socioeconomic area (AIHW 2016). Smoking rates in Fairfield LGA have remained constant between 2008–2013.

Case Study 3 – Puff Free Parks Project

In 2006, FCC adopted the Smoke-free Sporting Field and Playground Policy, which provided a ban on smoking within 10 metres of playgrounds and anywhere on sports fields. The Policy was reaffirmed by FCC in 2011. FCC was one of the first council to implement a Policy and by 2009, 38% of the 152 councils in NSW had adopted a smoke-free areas policy (Heart Foundation 2009).

FCC undertook a range of strategies to promote the Policy, with particular focus on sports clubs and young people which included:

- Community Awareness: Media launch with Sydney Swans and Sydney FC Soccer Club. World no tobacco Day promotions, Engaging schools – poster competitions and youth week events.
- Promotion and Implementation: Installation of signs at 160 playgrounds and 39 sports parks (90 sporting fields) at a cost of $12,780; distribution of promotional material to sporting clubs and at events. Condition 16 of conditions of hire required club officials to enforce the Policy.
- Monitoring: Enforcement of the Policy was via incentives to sporting clubs. Community Enforcement Officers undertook a program to monitor sport fields and playgrounds. Random monitoring of sports fields was also undertaken to evaluate the implementation of the Policy

Results

In the first three years of the Policy, a total of 87 inspections were undertaken targeting 20 fields across Fairfield LGA between 2007 and 2009. Council staff attended each field for a period of 30 minutes to observe smoking. Observation from random monitoring indicated that most club officials were aware of the policy, but visitors and spectators were not aware. There were only two fields were there no visible smokers.

While FCC was an early adopter of the Policy, many councils in NSW followed closely behind with 38% of

councils having some form of smoke-free areas policy by 2009 (Heart Foundation 2009). The FHP may have resulted in a FCC being a leader in the formation of the sector taking an interest in smoke-free environment, but the evidence shows many councils extended their Policy to include areas such as pools and bus shelters beyond that of Fairfield (Heart Foundation 2009). However, FCC undertook a comprehensive implementation plan to the Policy which was not evident in many other councils. There appears little to no advantage of the FHP other than be one of the first to adopt a Policy, resulting in FCC being leader in the sector.

In 2013, NSW Health amended the NSW Health Smoke Free Environment Act 2000 to include bans for public spaces which included spectator areas at public sports grounds and children's play equipment. At this time NSW Health became responsible for administration and enforcement.

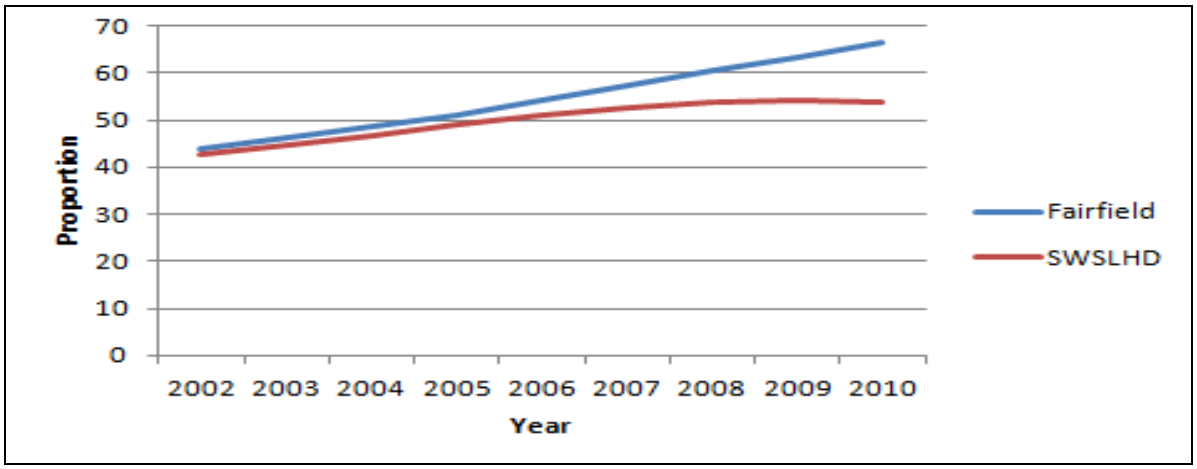
Nutrition – Overweight and Obesity

The main factors in reducing overweight and obesity are poor diet and inadequate physical activity, a healthy diet and regular physical activity assist in preventing chronic diseases such as heart disease, stroke, type 2-diabetes and colorectal cancer (AIHW 2016). Healthy eating is determined not only by individual taste preferences, but through complex interactions of individual, social, cultural, economic and environmental influences such as nutrition knowledge, cooking skills, availability of cooking equipment, food storage facilities, time, and the ability to physically and financially purchase and prepare food (Story et al 2008 sited in Byun 2011).

Literature shows that those who are most at risk of not eating nutritious foods include: people with low or no income, those who live in poor quality housing, people of Aboriginal and Torres Strait Islander backgrounds, people from non-English speaking backgrounds (especially refugees and recent migrants), single parents with young dependent children, the chronically ill and disabled, people living in remote or isolated areas and young unemployed people (Nolan et al 2006 sited in Byun 2011).

Figure 24 shows the recommended daily fruit consumption for Fairfield LGA in comparison to SWSLHD. The recommended intake for fruit consumption is consumption of two serves of per day (AIHW 2012).

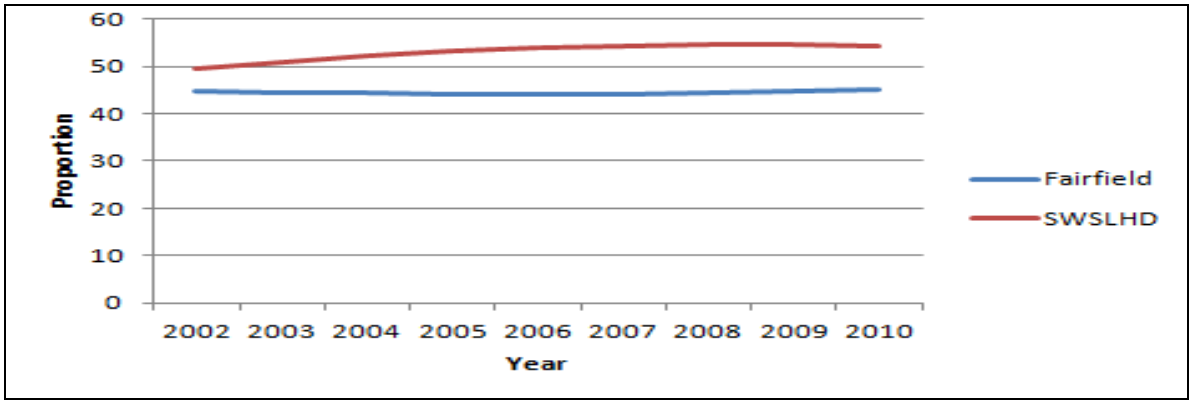
Figure 24 Recommended fruit consumption, 2002 to 2010



Source: Sainsbury 2013

As shown in Figure 24, Fairfield LGA between 2002 and 2010 had high fruit consumption which increased at a great rate than other SWSLHD areas.

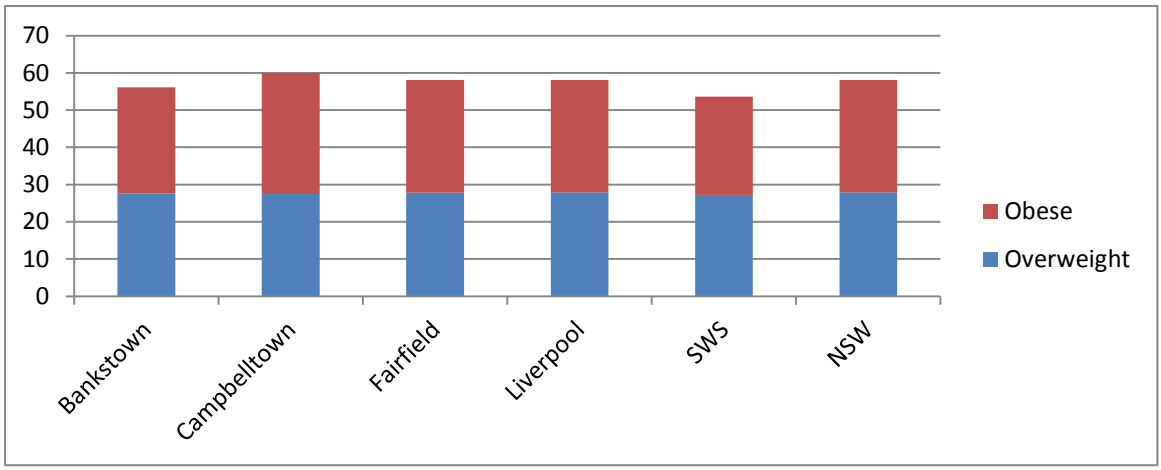
Figure 25 Overweight or Obese, 2002 to 2010



Source: Sainsbury 2013

Figure 25 shows that rates of overweigh or obesity in Fairfield LGA has remained stable, however there is a slight closing of the gap between Fairfield and SWSLHD.

Figure 26 present overweight and obesity data for 2011-2013 in comparison to neighbouring LGAs.



Source: PHIDU 2015

Figure 26 shows that Fairfield rates of overweight and obesity continue to be similar to that of neighbouring LGA despite Fairfield's high rates of disadvantage and migration.

Case Study 4 – Munch & Move

Munch & Move is a NSW Health initiative that supports the healthy development of children birth to 5 years by promoting physical activity, healthy eating and reduced small screen time. The program targets preschool, long day care and family day care services. The program was launched in 2008 at FCC Marlborough street preschool, demonstrating FCC commitment to health and a leader in the LG sector.

Since 2008 approximately 87% of Services in SWSLHD have attended training and are implementing the munch and move program.

FCC has a nutrition policy for all children's services which is consistent with the *Food Act 2003* and the *Dietary Guidelines for Children and Adolescents in Australia*. The objective of the nutrition policy is to ensure that childcare centres, in particular long day care centres, provide food and drinks that:

- Meet at least 50% of the children's daily nutritional requirements
- Are safe, nutritious, adequate in quantity, and varied
- Are appropriate to the developmental needs of the child and any special dietary needs of the child, and
- Are appropriate to the culture and religion of the child

To ensure compliance with the policy, menus are reviewed by a dietitian to ensure daily nutritional requirements are met.

In addition, FCC has vegetable gardens at all Early Learning Centres, which include a rainwater tanks, compost bins, worm farms and equipment necessary to establish and maintain a vegetable garden. The project aims to help children understand how to grow a healthy garden, the importance of fruit and vegetables as part of healthy eating, and providing opportunities to try fresh, healthy foods that they may not have tasted before.

Source: SSWAHS 2016 and Byun 2011

Fairfield LGA between 2002 and 2010 had high fruit consumption which increased at a greater rate than other SWSLHD areas while rates of overweigh or obesity remained stable, with a slight closing of the gap between Fairfield and SWSLHD, challenging the trend outlined in the literature in relation to disadvantage and refugee communities.

Reliability and Limitations

The chapter explored retrospective epidemiological health data to measure the effectiveness of the FHP by analysing available datasets to determine any changes to health risk behaviours in comparison to other neighbouring multicultural disadvantaged areas.

There are abundant limitations to data, while data has been obtained from reliable sources, the data has limitations as it is self-reported data. In addition, the validity of the data and analysis may be unreliable due to the following reasons:

- Different sequential data sources, limits the finding
- Inability to manipulate independent variables
- The pattern of migration and the constantly changing cohort of residents present challenges for the evaluation of the FHP
- Data used to report on health related behaviours are self-reported and prone to under-reporting
- Challenge of identifying a comparable LGA due to Fairfield LGA uniqueness as described in Chapter 3
- The inherent difficulty in measuring health risk behaviours further reduces the reliability of the data.

The most defining limitation remains the ability to demonstrate any causation between the results and the FHP. This doesn't mean the FHP failed to make a difference, rather evaluation in the social research setting provides challenges which are beyond the control of any researcher.

Conclusion

According to the literature you would expect Fairfield LGA to have poorer health outcome and higher risk taking behaviours (AIHW 2012). This is evident as Fairfield LGA has seen an increase in obesity rates (17.8% to 25.6%), diabetes (from 6.1% to 9.7%), high cholesterol (from 24.2% to 29.5%) and high blood pressure (from 20.5% to 31.3%) from 2002 to 2012. However, there have been some improvements over this time period also, for example smoking rates have decreased from 24.9% to 16.3% and the percentage of residents participating in adequate physical activity has increased slightly from 43.7% to 51.8% (SWSLHD).

When compared to other LGAs, Fairfield has lower levels of physical activity than other metropolitan LGAs, however rates of physical activity have kept pace with other SWSLHD. Considering the changing cohort, the level of disadvantaged and migration intake in Fairfield LGA this is an encouraging result for the FHP.

Smoking rates in Fairfield LGA have decreased at a greater rate than others in SWSLHD. However, more recent data shows that while the rate has continued to decrease, the rate of decline has not reduced at the same level as other LGAs. Likewise the consumption of fruit, while greater, has also increased at a similar level to other SWSLHD areas. Rates of overweight or obesity in Fairfield LGA has increased however there was a slight closing of the gap between Fairfield and SWSLHD. Rates continue to be similar to that of neighbouring LGA's despite Fairfield's high rates of disadvantage and migration which is encouraging for the FHP.

Due to the complexity of issues and lack of reliable data makes drawing any conclusions on the effectiveness of the FHP problematic. While the epidemiological data showed improvements in health related risk behaviours, eliciting causation is inconclusive, owing to the difficulty in undertaking social research and inability to identify a like-minded comparison area.

The four case studies provide an in-depth understanding of health initiatives, and provide valuable insights into the complexity of health in LG. The case studies show that FCC are early adopters of NSW Health initiatives through the FHP, certainly ensures that Fairfield are the leaders in the LG sectors when it comes to health initiatives. The benefit of the FHP goes far beyond its borders, providing benefits to Health and its uptake of programs across the LG sector.

In conclusion, the data was unfounded in identifying if the FHP made a difference to the health of Fairfield residents, while improvements in health related risk behaviours were observed and were encouraging for the FHP, the complexity of undertaking social research have proven to be to unintelligible. While out of scope for this research, exploring a comparable council from another State such as Victoria may have provided better comparisons in which to compare outputs.

Longitudinal research into health related behaviours at a local level is required for vulnerable populations to inform policy and determine public health benefits of such programs. There is a need to explore ways to obtain data to eliminate bias of self-reporting and invest in resources to assist in evaluation and monitoring outcomes of health promotion initiatives.

Chapter 8

Synthesis -
Findings & Conclusion

The research integrated mix method approaches, which added a lens and depth to the social research. While mixed method approaches are sometimes questioned as a viable research strategy in mainstream public health circles, the combination of approaches was necessary to obtain a comprehensive understanding of the FHP. Bauld *et al* (2010) proclaims that evaluating HPs is complex and challenging arguing that traditional evaluation approaches are often inappropriate for social interventions, suggesting a triangulation approach to measure the intricate links between activity and contexts of HPs is a more suitable methodology. Goldsmith et al (2007) maintains that synthesising quantitative and qualitative research in a single appraisal is a significant methodological challenge. While there is a potential for confusion through combining divergent research paradigms, it was necessary to understand the FHP. The following synthesis of data provides an account of the research questions.

Primary Research Question

Did working together achieve better outcomes than if we didn't work together?

The FHP over the decades had two primary objectives comprising (i) to improve the health behaviours of residents and (ii) to establish a partnership model for LG and health.

The research found that the FHP had achieved its objectives and that working together enabled collaborative advantage, where by creating something greater than the sum of its parts. If creating and sustaining cross-sector partnerships ought to be the fabrication of 'public value' (Moore 1995) then the FHP had succeeded in delivering joint projects, attracted additional resources, but most importantly influencing partner organisations policies, practices and strategic directions. The FHP was also an enabler for the LG sectors as it facilitated other councils interest and adoption of health initiatives.

All participants felt that it was the unintended consequences, where the greatest outcomes transpired. Both Health and FCC acknowledged that the FHP had influenced beyond the realms of the partnership.

> *"I believe it has been effective, while it has achieved through the milestones, it's the unintended that are the big achievements – the relationship as time when on – other things started happening" (FHP1)*

Aves (2001) described the projects as the glue, while the real outcomes came from the opportunity to influence and change policy. This theme emerged throughout the FHP research, with participants identifying that the FHP was most efficient in changing policy, inspire strategy and long term influence (FCC1). The case studies show that FCC were early adopters of Health initiatives, which 'opened doors' for Health, the benefit of the FHP went far beyond its borders, facilitating uptake of programs across the LG sector.

Drawing any conclusions on the impacts of the FHP was problematic. While the epidemiological data showed improvements in health related risk behaviours in some areas, eliciting causation was inconclusive, owing to the difficulty in undertaking social research and inability to identify a like-minded comparison area. Members of the FHP felt that the core objective was about two diverse organisations being able to show that they could work together and that LG accepted they have a role in improving health. While improving health was a priority, it was identified that demonstrating that the FHP made a difference was always going to be challenging.

> "*I didn't expect it to improve the health of the people of Fairfield – it may or may not, but it's only a small contributor, so you wouldn't be able to say with any certainty that it changed. The partnership works on health promotion and public health things, what we work on takes so long to bear fruit – it's never going to say it improved the health of people in Fairfield, it's not the goal"* (SWSLHD1)

Bryson et al (2006) characterises partnerships as "*the linking or sharing of information, resources, activities, and capabilities by organisations in two or more sectors to achieve jointly an outcome that could not be attained*

alone" (Bryson et al 2006:44). The research found that the FHP achieved more together than one could have accomplished alone.

> *"You would think that at some point someone would say we can do this on our own we have learnt how to do it – but It's more than a project"* (FHP2)

A prognostic prediction on what might have occurred in the absence of the partnership continues to be the most defining limitation, with the inability to demonstrate any causation between the results and the FHP.

Leung, 2012 identified that cross-sector partnerships enables 'collaborative advantage' whereby organisations working together generate something greater than the sum of their parts. The FHP is a successful partnership, with participants extremely satisfied with all the elements required to build effective partnerships. All participants felt that the FHP had achieved its objectives and that working together enabled collaborative advantage, whereby creating something greater than the sum of its parts, public value. FHP had successes in delivering joint projects, attracted additional resources, but most importantly it influenced both partner organisations policies, practices and strategic directions. The FHP was also identified as an enabler for the LG sectors involvement in health issues, as it facilitated other councils interest and adoption of health initiatives. At the same time, all acknowledge the difficulty in measuring any changes at a population level.

Secondary Research Question

What are the characteristics of an effective partnership in health prevention?

The evaluation of the literature and FHP showed that HPs develop on a continuum of complexity and embrace a series of multifaceted elements and functions. Together these provide the successful recipe for effective partnerships.

The literature identified six increasing functions of partnership from networking to mobilising where partnerships increase in complexity, investment and impact. The research identified that the FHP operated at the highest form of partnership, described in academic literature as transformational partnership or mobilising. Interviewees identified that the FHP transverse the continuum of partnership functions from networking to collaborating to mobilising, identifying numerous ways where the organisations made themselves vulnerable to the influence of each other, which stimulated innovation in policies and practices.

> *"Certainly at the mobilising end of the spectrum- it also has had the opportunity and ability to influence policy across other LGAs"* (SWSLDH2)

The literature also ascertained nine elements of effective partnerships which incorporate four capabilities of governance, organisational, individual and achievement and accountability. The research found that the FHP had matured and evolved in capability over time, which spanned across all elements of effective partnerships.

FHP members were extremely satisfied with all elements of the partnership with Trust (9.5) and Leadership (9.3) being the highest rated elements, followed equally by Relationship (9.2), Shared Resources (9.2) and Communication (9.2). Partners were least satisfied with Evaluation (8.0) and Power and Control (8.5) however both were still rated highly satisfied by participants. Trust, Relationship and Shard Resources received, on average a higher satisfaction score than importance. On all elements of effective partnership there was less than 0.5 ranking difference in all elements, except evaluation, which was still rated as highly satisfied.

Based on these findings, FHP was a successful partnership which embraced all the capabilities required to build an effective partnership. The longevity of the partnership was seen as a testament to it success.

> *"Too good an initiative to let it drop – the benefits are in the particular way we influence each other"* (SWSLHD1).

What, if any, were the unintended consequences of working together?

All participants felt that it was the unintended consequences, where the greatest results where experienced. All partners identified ways in which the FHP partnership influences services and practice from both within the partnership and beyond. The research identified numerous unintended consequences which have impacted the LG sector. The Case Studies showed that FHP facilitated FCC were a leader and early adopters of health initiatives, which set the foundations for the LG sector to adopt there role in improving health.

The foremost identified inadvertent outcome was 'knowing who to talk to' and 'knowing that they wanted to help'. Norris-Tirrell and Clay (2010) describe the requirement for managers and partners to think differently and work beyond disciplines and borders. The FHP facilitated networks beyond the partnership as the organisations created a culture of joined up governance where workers were open to operating differently.

> *"Outcomes – relationship and the type of work – council took on health initiates. 'Get Healthy at Work' health supported the Work Health and Safety team at FCC. 'Make Health Normal' campaign – health contacted council to help promote in the LGA (FHP1)*

> *"Smoking legislation – relationship with council, place managers and NSW health officers meet regularly on tobacco issues e.g. issue with smoking in specific areas e.g. restaurant down the road allows smoking – they can talk and ask that they come out and have a look. Now they're just a phone call away. Opens up communication" (FHP1)*

Another unintended benefit was the ability to attract additional resources, which had implications on the number of programs conducted in the Fairfield LGA. Partners of the FHP contributed a combined total of $1,274,000 over the life of the project, the Health Communities Initiative attracted a single grant of $972,000, almost doubling the resources of the partnership.

> *"Where would we be without the partnership? Working on our own, challenges in seeking funding. Because we have a relationship with health, it gives us 'weight' when applying for grants"* (FHP2)

The FHP has transformed partners and influenced agendas beyond the realms of the partnership, creating system-wide impact and creating capacity which reaches scales which create lasting impacts.

Did the Fairfield Health Partnership make any difference to the health of Fairfield residents in relation to health related risk behaviours?

The literature and analysis of the demographic of Fairfield LGA ascertains that Fairfield residents are more likely to have poorer health and greater levels of health related risk behaviours in comparison to other LGA's.

The research found that many health related risk behaviours improved over the life of the FHP however, it was equivocal if these variations were a direct cause of the FHP. Bauld *et al* (2010) characterised the complexity of evaluating HPs as complex and challenging as methods are inappropriate for social interventions. These limitations were evident, and made even more difficult due to the inability to identify a like-minded comparison area.

Due to the intricacy of determinates of health, the findings of whether the FHP made any difference to the health related risk behaviours was inconclusive. Notwithstanding, while cause and effect could not be substantiated, certainly the health behaviours of Fairfield residents in some factors are better than the literature would suggest. Considering the changing cohort, the level of disadvantaged and migration intake in Fairfield LGA this is an encouraging result for the FHP, despite the poor health indictors of Fairfield residents.

All partners comprehended the difficulty in prognostic or outcome predictions due to the complexity of issues.

> "*I didn't expect it to improve the health of the people of Fairfield – it may or may not, but it's only a small contributor, so you wouldn't be able to say with any certainty that it changed. The partnership works on health promotion and public health things we work on take so long to bear fruit – it's never going to say it improved the health of people in Fairfield"* (SWSLHD1)

In conclusion, there was insufficient evidence to make strong conclusions about the effect of partnerships on population-health outcomes, while improvements in health related risk behaviours were observed and were encouraging, establishing the causal linking between the FHP and its relationship to health outcomes was found to be inconclusive.

Discussion – Implications for future practice

Due to the emergent research, the sequential mixed ex post factor research design was adopted. What resulted was a complex blend of mixed methods across numerous data collection points to obtain an understanding of the FHP. Another dimension of complexity was added due to the impenetrability of measuring health related risk behaviours. In terms of data alignment it was challenging to synthesising quantitative and qualitative research in a single appraisal. What resulted was the conjoined synthesis of data sources were supplemented and segregated to answer different components of the research questions.

This research adds to the growing body of knowledge concerning the use of mixed methods research designs in social research. Bauld *et al* (2010) argues that experimental approaches for evaluation are often inappropriate for social interventions. However, as social policy-makers demonstrate, such research is necessary to fully understand and address health-related issues. Research norms and scientific dogma regarding appropriate methods for evaluating HPs need to shift to a new more integrative paradigm. There is much room for improvement in reviewing prognostic and outcome predictions of HPs, which are prone to influences beyond its control, to prevent the masquerade that currently exists with current evaluation models.

The finding of the research concluded that the FHP did achieve 'collaborative advantage' as working together resulted in changes to policy, inspired strategy directions and had long term influence beyond the spheres of the partnership. The FHP operated at the highest function of partnership, described as mobilising. The FHP matured and evolved in capability over time, which spanned all elements of effective partnerships creating system-wide impact and creating capacity which reaches scales which create lasting impacts. However, there was insufficient evidence to make strong conclusions about the effect of partnerships on population-health outcomes, while improvements in health related risk behaviours were observed establishing the causal linking between the FHP and its relationship to health outcomes was inconclusive.

> *"We recognised our particular community have significant problems in specific areas – while we may not have solved the issues, the FHP has been successful – I think it would be a worse problem, had the FHP not been there" (FCC2)*

It was envisaged that the FHP would identify a sustainable methodology for joint planning and delivery of services across LG and Health which could then be replicated in other areas. The model of the FHP, its functionality and success is clearly demonstrated and recorded, and now available for others to adopt, replicate or amend. The following Capability Framework provides a platform in which to develop and evolve partnerships across the LG sector. Recent changes to the *LG Act 1993* cement LG role in facilitating health communities and establishes a benchmark that LG will work co-operatively with other councils and state government

Chapter 9

Towards a Partnership Capability Framework

The following PCF has its foundations set within empirical literature and has been further refined through using the FHP as a case study during qualitative interviews and audit of activity. The PCF established the successful ingredient for effective partnerships along a continuum of functions and elements. While the Framework is underpinned and established on a health platform, it provides a recipe for LG on how to work effectively together beyond the realms of health.

The Framework establishes six functions of partnerships which increase in complexity from networking through to mobilising where partnerships increase in complexity, investment and impact and include a hierarchy from:

1. Networking: exchange of information (Riggs *et al* 2013:4)
2. Philanthropic: financial contribution such as donation, grant or contract (BSR 2012:10
3. Coordination: altering activities for mutual benefit and to achieve a common purpose (Riggs *et al* 2013:4)
4. Cooperating: sharing resource for mutual benefit and to achieve a common purpose (Riggs *et al* 2013:4)
5. Collaborating: enhancing the capacity of another for mutual benefit and to achieve a common purpose which has a collective impact. Shared risks and responsibilities with mutual benefit (Riggs *et al* 2013:4 and Flood et al 2015 and UN Global Compact)
6. Mobilising: Benefit beyond that of the partnership where organisations make themselves vulnerable to the influence of others, stimulating innovation in their policies and practices (UN Global Compact: 10 and BSR 2012:10).

The Framework ascertained nine elements of effective partnerships which incorporate the four capabilities of governance, organisational, individual and public value. Detail of each of the nine elements is presented in Chapter 2, and 6 of the research which includes:

- Governance Capability: Commitment, Power & Control
- Organisational Capability: Relationship, Shared Resources and Shared Vision
- Individual Capability: Leadership, Trust and Communication
- Public Value: Achievement and Accountability

The PCF (below) presents a successful recipe for effective partnerships. The Framework describes the processes, structures, culture, qualities and values required to develop effective partnerships along a continuum. The Framework provides a common platform and a systematic, integrated approach to commence discussions with prospective partners on the level and function that the partnership should build its foundations. The success of the Framework relies on partner's ownership and the degree to which capabilities are integrated and embedded across the elements and functions.

The development of a Framework is important for the LG sector as recent changes to the *LG Act 1993* cement LG role in facilitating health communities and establishes a benchmark that LG will work cooperatively with other councils and state government (Government Amendment (Governance and Planning) Bill 2016). Cooperating partnerships are the fourth tier along other continuum of complexity in the Framework, and present a minimum standard for LG partnerships. The PCF facilitates LG to move beyond a cooperative partnership to one of collaboration and mobilising, where the public value warrants.

Coming together is a beginning, staying together is progress, and working together is success. — Henry Ford

Partnership Capability Framework

PUPLIC VALUE (Functions / Elements)		Philanthropic	Networking	Coordinating	Cooperating	Collaborating	Mobilising
Governance Capability	Commitment			Short-term gain	Build stakeholder relationships	Long -term gain Transparent Optimise performance	Political & Senior management – multiple levels Combining perspectives
	Power & Control	Imbalance of power	Little power	Systems and policy	Program or interventions Governance arrangements Decision making	Sharing of risks Sharing of responsibilities Design innovative solutions Power imbalance addressed	Shared agenda Central infrastructure Collective Impact Decentralised control
Organisational Capability	Relationship	Discrete effort – contractual	Exchange of Information	Key segments agreed	Leverage core competency Open and honest dealings	Enhancing capacity of another Mutually beneficial Co-creates solutions	Create capacity Enabling environment Joint solutions Like each other – generally
	Shared Resources	Contracts and financial contributions	Disseminates information	Altering activity for mutual benefit Tangible action	Sharing resources for mutual benefit Mobilise resources	Sharing of resources Formal knowledge sharing Strengths based	Influencing Formal transfer of function Integration
	Shared Vision			Achieve a common purpose	To achieve a common purpose Opportunistic	Strategic - Influence Shared purpose & decisions Shared language	Influences beyond the partnership Whole system of influence
Individual Capability	Leadership				Defined values and mission	Design innovative solutions Active learning Address conflict Foresight	Joined- up culture Supportive environments Innovation – architect Shape change
	Trust	Contractual relationship	Sharing of information	Sense of good will and generosity	Common bond Alliances Reciprocity	Bi-lateral agreement Trust and respect Ownership	Systematically changing the rules Inspires confidence
	Communication	Contracts and reports	Meetings and minutes Listening and Sharing	Persuade Adapts style to audience	Encourage team work Adapts style and context	Continuous Communication Language and culture Deal with conflict constructively	Culture of problem solving, upfront & cohesiveness Deep understanding
Public Value	Achievement & Accountability	Contracts Reports Process measures Deliverables	Satisfaction Surveys Evaluation	Focus on achieving organisational priorities Shared activity and projects	Focus on intervention Deliver reliable results Sets targets, measure activity	Public Value Evaluation of partnership as well as interventions Monitors performance Impact measurement	Shared measurement System-wide impact Unexpected outcomes Challenges status quo Performance culture

Adapted from: O'Donnell 2012; Riggs et al 2013; UNGC; BSR 2012; Koelen et al 2012; Lasker et al 2001; Carey & Crammond 2016; Cameron et al 2014; Flood et al 2016; Roussos and Fawcett 2000;Dowling et al 2004; Bryson et al 2006; Rantala et al 2014; FCC 2016.

Chapter 10

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Attachment 1: Demographic profile of Fairfield City in comparison to other Sydney Metropolitan LGAs with high migration and socio-economic disadvantage

Population Characteristic	Auburn	Bankstown	Blacktown	Campbelltown	Fairfield	Holroyd	Liverpool	Parramatta	NSW
Total persons (ERP 2015)	88,059	203,202	339,328	158,941	204,442	113,294	204,594	203,167	
Population projections 2031[1]	130,600	240,800	473,300	215,750	239,900	136,000	288,950	253,900	
Land area	32Km^2	77Km^2	240Km^2	312Km^2	102Km^2	40Km^2	306Km^2	84Km^2	
Population density (Persons per hectare)	27.11	26.45	14.13	5.09	20.12	28.19	6.70	27.48	
Aboriginal & Torres Strait Islander (ERP 2013)[4]	0.8%	0.9%	3.1	**3.7%**	0.8%	0.9%	1.7%	1.0%	2.5%
Persons born overseas	**56.7%**	37.6%	37.6	28.1%	52.5%	43.1%	39.8%	44.5%	25.7%
Language other than English spoken at home	**70.1%**	55%	37%	25.2%	**70.0%**	51.0%	49.8%	45.5%	27.5%
English proficiency (English not well or at all)	18.7%	11.0%	4.7%	3.2%	**20.4%**	8.1%	8.7%	7.9%	3.9%
Humanitarian Stream Arrivals 2010-2015[3]	1,922	824	2,050	349	**5,816**	1,093	2,899	1,647	
Family Visa Stream Arrivals 2010 - 2015[3]	5,556	6,337	**7,912**	3,553	7,660	4,542	5,291	7,600	
Skilled Migrant Arrivals 2010-2015[3]	5,809	2,847	9,982	5,930	**1,146**	7,450	2,727	11,918	
Education									
Completed Yr12 or equivalent	56%	47%	49%	**41.1%**	44%	51%	48.9%	62.5%	62.5%
% no qualifications	46.6%	51.4%	47.6%	50.2%	**60.3%**	45.2%	50.1%	35.3%	42.8%
Employment									
Total labour force	31,628	75,608	144,098	70,233	75,949	45,582	80,192	98,459	3,334,857
Employed full-time	59.0%	59.4%	63.6%	62.0%	58.8%	62.0%	63.3%	63.3%	60.2%
Unemployed	8.6%	7.6%	7.2	7.4%	**9.7%**	7.2%	7.0%	6.5%	6.5%
% undertook voluntary work 2011[4]	9.6%	10.1%%	11.6%	11.8%	**7.3%**	10.5%	9.5%	13.2%	
Income									
Medium household income ($/week)	$1,160	$1,091	$1,388	$1,251	$1,022	$1,209	$2,199	$1,310	$1,237
% on aged pension 2014[4]	75.8%	76.4%	79.4%	79.2%	**81.6%**	76.3%	78.6%	75.9%	
% on Disability Support Pensioners 2014[4]	4.1%	6.1%	5.3%	6.4%	**7.1%**	5.5%	6.0%	5.1%	
Family Characteristics									
Couples with children	40%	41%	44%	48.6%	52%	38%	56.7%	36%	36.0%
Couples without children	5%	8%	6%	27.5%	23.2%	7%	23.7%	7%	23.4%
One parent families	11.2%	%	15.2%	22.3%	**22.6%**	12.7%	18.2%	9.6%	9.6%

Dwelling Characteristics									
Total number of dwellings	24,451	62,741	100,879	51,333	60,193	34,613	56,470	74,679	2,864,531
# of social housing dwellings	4.1%	**9.7%**	9.0%	11.4%	8.0%	7.2%	8.1%	6.0%	4.9%
% households rent assistance 2014[4]	27.2%	22.3%	20.1%	20.0%	**34.8%**	23.7%	24.7%	19.2%	
% in mortgage stress 2014[4]	22.8%	20.4%	12.8%	13.4%	**24.2%**	15.9%	7.9%	7.9%	
Internet Connection									
% of dwellings without internet	16.8%	22.4%	17.5%	18.7%	**25.3%**	20.1%	18.3%	13.6%	19.4%
Disadvantaged									
SEIFA Index of Disadvantaged	916.7	931.7	968.5	944.8	**854**	965.6	951	1032.8	1021.8
Ranking in NSW (1=most disadvantaged)	17	30	77	43	**3**	74	51	125	NA
Health Status[4]									
Children Developmentally Vulnerable on one or more domains	27.1%	**28.2%**	23.8%	23.7%	27.8%	19.7%	22.4%	22.0%	
Persons 18+ self-assessed health status as fair/ poor (ASR per 100)	20.7	19.8	17.0	12.3	**25.1**	17.8	18.7	17.1	16.6
% low birth weight babies	5.8%	5.8%	**7.5%**	**7.5%**	7.1%	6.6%	6.6%	6.0%	6.1%
% smoking during pregnancy	4.8%	13.5%	13.4%	**26.6%**	13.5%	6.2%	14.9%	4.6%	12.0%
Persons 18+ with diabetes mellitus (ASR per 100)	10.8	8.0	7.8	6.6	**12.3**	8.2	9.5	6.8	5.8
Persons 18+ with high blood cholesterol (ARS per 100)	30.9	31.3	31.3	31.4	30.6	31.1	31.2	31.5	**32.4**
Persons 18+ who were current smokers (ARS per 100)	15.0	16.4	16.5	**18.3**	17.5	15.8	16.9	14.1	16.2
Persons 18+ consuming alcohol at levels considered high risk to health (ASR per 100)	4.5	4.7	4.7	**4.9**	4.8	4.6	4.6	4.6	4.8
Persons 18+ who were overweight (but not obese (ASR per 100)	32.6	34.9	34.4	**34.6**	34.3	34.5	35.1	33.9	**34.6**
Persons 18+ who were obese (ASR per 100)	22.4	28.5	28.8	32.5	**30.3**	27.3	30.2	24.5	26.4

Source: 1. ABS 2016 2. ABS 2011 3. DSS 2016 4. PHIDU 2015 5. DP&E 2014

Similarities and Differences

National Institute of Economic and Industry Research (2013) undertook a cluster/ factor analysis to determine LGAs with similar characteristics in NSW. The report uses 14 factors to determine similarities and differences. LGAs were grouped into clusters where similarities were identified. They were then groups via a numerical coding. Fairfield LGA was found to be unique with little in common with other metropolitan councils. As can be seen from the NIEIR analysis Fairfield LGA is different to neighbouring south west LGAs, due to its level of disadvantaged and multiculturally diverse community. Fairfield City has specific unique needs within the Metropolitan Sydney area as outlined below) (NIEIR 2013).

Similarities and Difference cluster analysis

LGA	Age Structure	Pop Growth	Rate Base	Dwellings	Family	Labour Market	Education	Income*	Knowledge Economy	Transport	Wealth	Religion	Language	Born Overseas	% similarity with Fairfield LGA
Auburn	2	1	2	2	1	3	3	4	5	2	2	1	1	1	29%
Bankstown	4	4	4	4	1	3	2	4	5	4	2	1	3	3	36%
Blacktown	4	1	4	4	5	3	2	4	5	4	5	4	3	3	50%
Camden	4	4	4	4	5	1	5	2	5	4	5	0	0	0	36%
Campbelltown	4	7	4	4	5	3	2	4	5	4	4	3	2	3	43%
Fairfield	2	1	4	4	5	5	3	4	8	4	5	3	3	2	-
Holroyd	2	1	4	2	1	3	2	4	5	4	5	3	2	3	50%
Liverpool	4	4	4	4	5	3	2	4	5	4	5	3	2	3	50%
Parramatta	2	1	4	2	1	3	1	2	5	2	2	8	2	1	29%
Penrith	4	7	4	4	5	3	5	2	5	4	5	3	0	0	43%

Source NIEIR 2013 *The authors of the report have combined middle and low incomes – it is considered that this methodology is not useful as a comparison indicator

Upon examination of the Report, it can be seen that Fairfield City has a 7/14 (50%) similarity with Liverpool, Holroyd and Blacktown LGAs, concluding that Fairfield City is very different to areas surrounding it. The methodology for clustering Income is challenged below, resulting in even more distinction between Fairfield and other LGA in metropolitan Sydney. The difference can be observed in the following seven cluster maps and analysis of the Income factor (NIEIR 2013).

1. Age structure

As shown in Figure 1 Fairfield's age structure is different to all other councils in the southwest. Similar LGAs are found mainly in a belt around middle Sydney running from the Warringah Peninsula through Willoughby, Parramatta, Fairfield, Holroyd and Auburn to Canterbury, Sutherland and Wollongong.

2. Recent Population Growth

As shown in Figure 2, Fairfield City was found to have similar population growths as the inner and middle suburbs of Sydney such as Holroyd, Blacktown, Parramatta and Auburn. The population growth rate was above State average, with a balance between overseas arrivals and new births. As a non-growth area Fairfield City has more in common with middle Sydney than councils in the south west.

3. Knowledge Economy

The Fairfield cluster returns low values for all the listed indicators of the knowledge economy. The cluster includes mainly rural and inland LGAs and spreads from northern New England down to some of the North Coast LGAs. It includes Fairfield LGA in the metropolitan area which is the only metropolitan LGA grouped into this cluster. Similar to the SEIFA Index of Disadvantage, Fairfield City has much in common with rural and remote communities and has unique qualities in the Sydney metropolitan area.

Figure 1. Age Structure

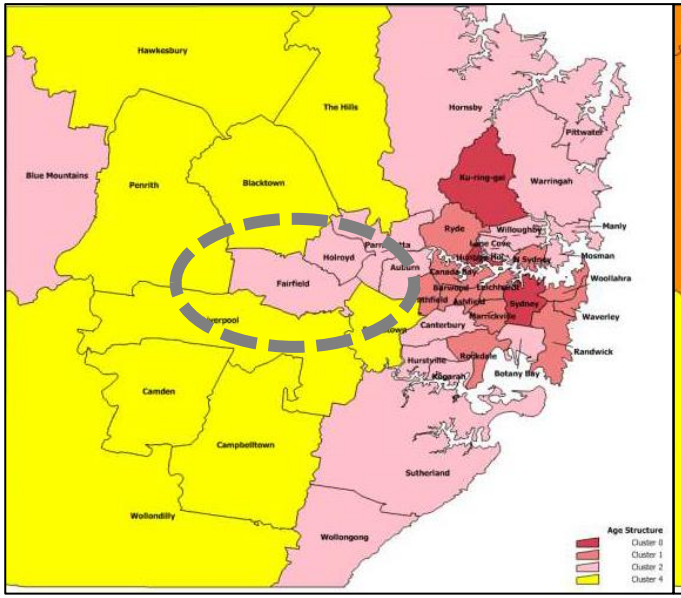


Figure 2. Population Growth

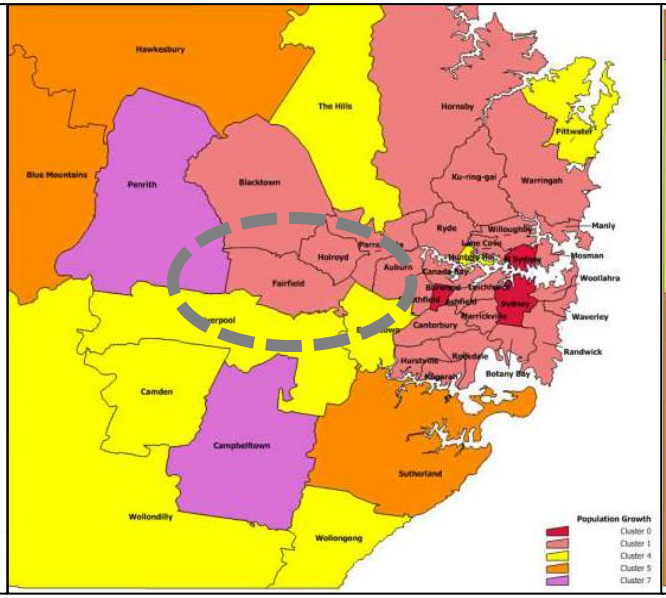
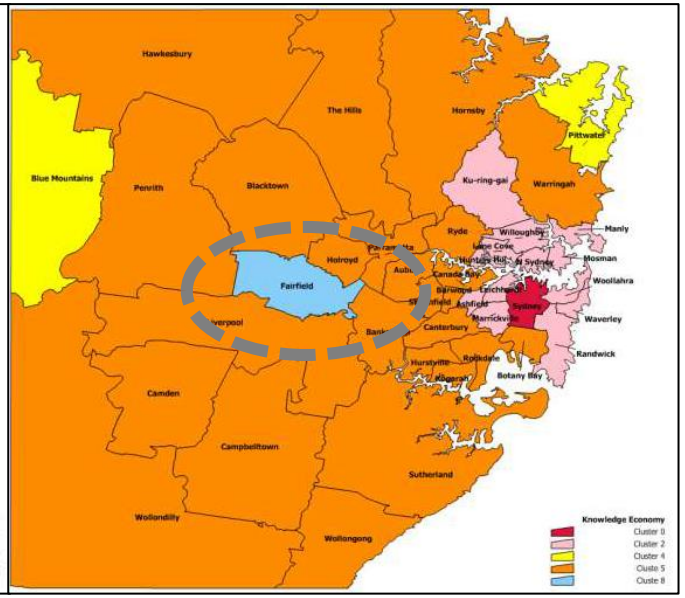


Figure 3 Knowledge Economy



4. Born Oversees

Birthplace was identified as a significant indicator of cultural similarities between LGA populations by the NIEIR. Fairfield LGA (shown in Figure 4) is unique and unlike its neighbouring LGA's. Less than half of Fairfield's residents were Australian born, with significant representation from South East Asia and West Asia. Liverpool, Campbelltown, Blacktown and Bankstown have around 60 per cent Australian born, with significantly more from Southern and Eastern Europe. Fairfield City has a unique role to play as a settlement City for both migrants and businesses.

5. Language

Fairfield and Bankstown LGAs provide a unique cluster where English is used at home by less than a third of households. South Asian languages are more prominent than East Asian while South West Asian and East European languages are also widely spoken. In Liverpool, Blacktown, Holroyd and Campbelltown LGAs, about half of all households use English at home with a mix of other languages among which the East Asian languages are prominent.

6. Education

Fairfield and Auburn LGAs are represented by a high proportion of people born overseas who speak poor or no English. They have a moderate Year 12 achievement and fairly low proportions of residents with professional qualifications. Approximately 20% of Fairfield City residents do not speak English fluently. Only 9.2% have a Bachelor or higher degree, while over 60% have no qualifications at all.

Figure 4. Born Overseas

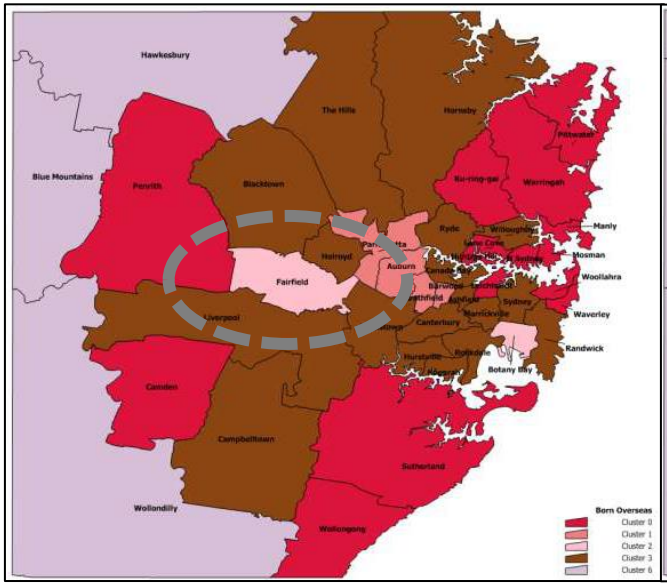


Figure 5. Language

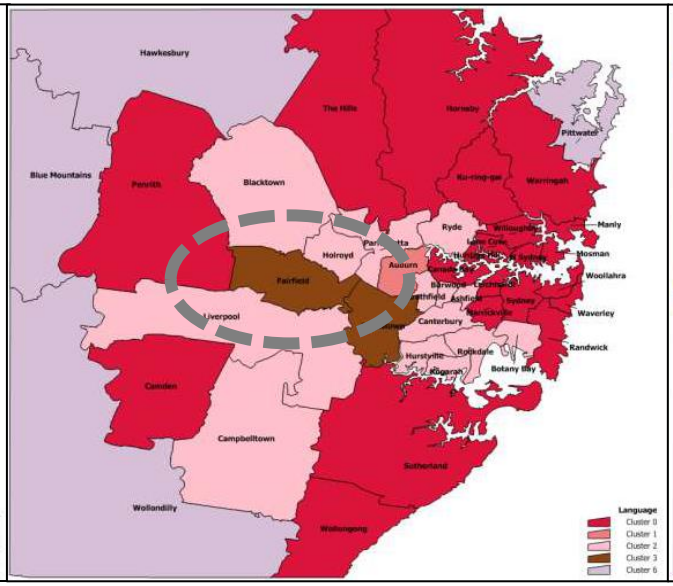
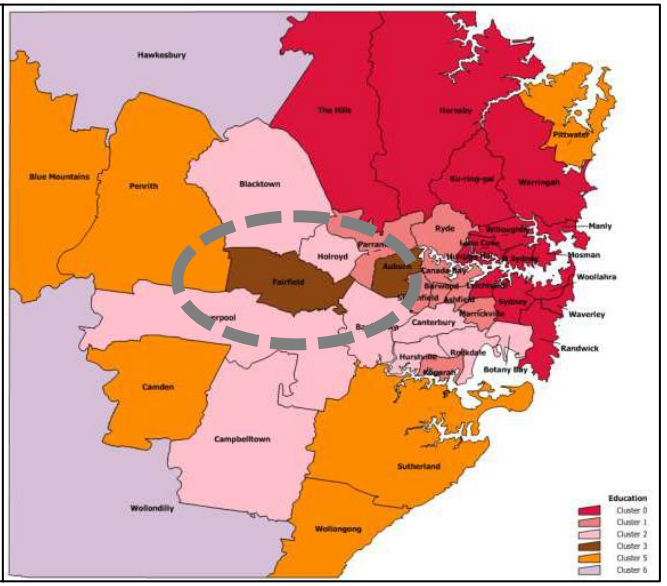


Figure 6. Education



7. Labour Market

Cluster 5 (Orange) is found all along the North Coast and New England along with several inland LGAs such as Bourke and Brewarrina. Fairfield LGA is the only metropolitan council identified within this cluster, again demonstrating the areas uniqueness. In this cluster both structural and NIEIR-adjusted unemployment are high. Social security take-up is also quite high, and hours of work available a week are low and the employment rate is low.

8. Income

The NIEIR analysis combines middle and low incomes into one cluster which creates a cluster with 70 LGAs, nearly half the LGAs of the State. The analysis groups Fairfield with a SEIFA score of 854 the most disadvantaged LGA in metropolitan Sydney in the same cluster as the Hills Shire which has a score of 1101 being one of the sixth most affluent LGA's. Further analysis shows that Fairfield City has much lower incomes (ABS 2011).

In 2011, Fairfield's median household income was equivalent to 71% of Sydney's Greater Statistical Area household median income. Another way to interpret these statistics is that Fairfield LGA's median household income was 29% lower than Greater Sydney median household income. What is concerning is that in 2006 Fairfield's median household incomes were 24% lower than the Greater Sydney while in 2011 they were 29%. The income inequality between Fairfield LGA and Greater Sydney has increased by 5% (ABS 2011).

Fairfield LGA had a relatively slow income growth over the 5 year period of 17%, while the median household income growth for Greater Sydney was 25% over the same period (ABS 2011).

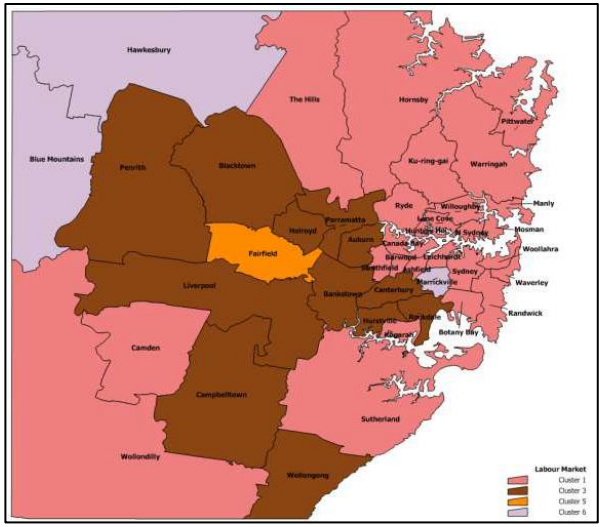


Figure 7 Labour Market

Attachment 2: Chronology of the Fairfield Health Partnership

The Fairfield Health Partnership was established in 1995. Table 1 provides an account of the Partnership since its inception analysing evaluation processes undertaken via an audit of files (FCC 2016).

Timeline	Detail	Partners	Priorities	Activities	Budget Resources	Evaluation findings / Notes
1994	-	FCC SWSAHS Div. of GP Fairfield Hospital F/F Comm. Health	Consultation	FCC completed community plan and established health strategy group. Decision to hold a community consultation to define needs	-	
1995	CPO - 21hr per week Executive Work plan	3 reps Health 3 reps from FCC 3 reps from NGOs 3 resident reps NGO and residents nominated and voted onto Executive for a 2-year period	Establishment of Community Project Officer (CPO) position 21 hrs per week, jointly funded by Health and FCC for 12-months.	Feb: Community Consultation workshop Feb: F/F Health Forum established March: P/T project worker (21hrs week) March: First F/F Health Forum meeting	Health 25K FCC 25K	Issues paper developed
July 1996	MOU covers the period from 1 July 1996 - 30 June 1998 CPO - 21hr per week Executive TOR Work plan	*South West Sydney Area Health Service:* General Manager – Fairfield Hospital, Director Community & Allied Health; Director, Division of General Practice *Fairfield City Council* Councillor; Program manager Health Cities, Team leader Environment and Health Branch NGO's - SWAP - YADA	Priorities - Mental health - Aboriginal health - NESB health Focus areas - Drug & Alcohol - Needle & syringe disposal - Unemployment - Immunisation - Health transport		Health 25K FCC 25K	Interim Review – Interviewed HF members – consultant mapping of works. Positive findings: - Health Forum was a useful tool for collaborative project development. - Good for pooling resources What needs work - Greater role clarity - Greater accountability - Adequate resourcing - Effective reporting mechanism -
1997					Health 25K FCC 25K	

Timeline	Detail	Partners	Priorities	Activities	Budget Resources	Evaluation findings / Notes
July 1998		- IWHS Residents - Three NGO and residents nominated and voted onto Executive for a 2-year period			Health 25K FCC 25K	Review and Discussion Paper developed
July 1998 1999 2000 2001 June 2002	MOU covers the period from 1 July 1998 - 30 June 2002 CPO - 21hr per week Executive TOR Work plan	*South West Sydney Area Health Service:* General Manager – Fairfield Hospital, Director Community & Allied Health; Director, Division of General Practice *Fairfield City Council* Councillor; Program Manager Health Cities, Team leader Environment and Health Branch NGO's - Family Planning - East Fairfield Community - IWHS Residents - Three	Priorities - Mental health - Aboriginal health - NESB health Focus areas - Drug & Alcohol - Needle & syringe disposal - Unemployment - Immunisation - Health transport		Health 25K FCC 25K Health 25K FCC 25K Health 25K FCC 25K Health 25K FCC 25K Health 25K FCC 25K	
2002	Executive TOR Work plan	*Sydney South West Area Health Service:* General Manager – Fairfield Hospital, Director Community & Allied Health; Director, Division of General Practice *Fairfield City Council* Councillor; Program Manager Health Cities, Team leader	Protect and promote health of Fairfield residents and people visiting and working in the LGA Priorities - Nutrition - Physical Activity - Mental health - Drugs and Alcohol		Health 26K FCC 26K	Review Positive findings - Benefits outweighed the costs - Common vision - Shared understanding of what motivated the partnership - Good process for decision making - Communication, managing

Timeline	Detail	Partners	Priorities	Activities	Budget Resources	Evaluation findings / Notes
		Environment and Health Branch NGO's - IWHS - Family Planning - East Fairfield Community Residents - Three				external conflict and collating of information. What needs work - Organisational structure - Membership - Role clarification - Directions setting - Review process - Documenting outcomes - Resolving conflict - Monitoring resources - Need performance target
2003	CPO - 21hr per week Executive TOR Work plan	*Sydney South West Area Health Service:* General Manager – Fairfield Hospital, Director Community & Allied Health; Director, Division of General Practice *Fairfield City Council:* Councillor; Program Manager Health Cities, Team leader Environment and Health Branch NGO's - IWHS - Family Planning - East Fairfield Community Residents - Two	**Priorities** - Mental health - Smoking and Alcohol - Physical Activity and Nutrition **Focus Areas** - Arts for health - Disability and rehabilitation - Access to health services - Gambling - Primary health care	Options paper developed that looked at 7-year history, current structure	Health 26K FCC 26K	Findings - Membership generated challenges for executive members - Model competing with new Health Consumer Participation Committees - Project beneficial, however could continue without the HF structure. Extensive consultation on 2003, it was agreed to end the Fairfield Health Forum and being an entirely new partnership model. Focused on operations and planning between FCC and Health.
2004			Pilot of new Partnership model – aimed improve interaction between Council and Health	Agreement between health and council developed acknowledging a need to work together	Health 26K FCC 26K	
July	MOU covers	*Sydney South West Area*	1. Establish the Executive Group for	Executive Committee established	Health 30K	

Timeline	Detail	Partners	Priorities	Activities	Budget Resources	Evaluation findings / Notes
2005 June 2006	the period from 1 July 2005 - 30 June 2006 CPO - 21hr per week Executive TOR Work plan	*Health Service:* General Manager – Fairfield Hospital, Director Community & Allied Health; Director Population Health. *Fairfield City Council* Program Manager Health Cities, Manager, Community Life	the purpose of developing and implementing a model for joint service delivery 2. Develop project based initiatives **Priority areas**: - Physical Activity - Nutrition - Respiratory Asthma - Cardiac - Drugs and Alcohol - Tobacco - Mental Health		FCC 30K	
July 2006 June 2007	MOU covers the period from 1 July 2006 - 30 June 2007 CPO - 21hr per week Executive TOR Work plan Introduced Strategic Working Group	*Sydney South West Area Health Service:* Director Population Health, General Manager Community Health, Director Children and Family Clinical Services, Director Health Promotion, PA Program Manager, Tobacco Program Manager, Strategic Partnership program Manager *Fairfield City Council* Mayor, City Manager; Executive Manager Outcomes, Manager, Community Life	**Strategic** - Joint Planning - Sharing information - Gap and strategy development - Emerging trends - Adding value to existing initiatives **Projects** - Smoke-free sporting fields and playgrounds - Physical Activity - Health Orientation Tours	**Puff-free parks** - Research Group established - Youth week – 200 YP participated in workshop - Workshops FF leisure centre to build giant cigarette - two TV stations attended. - Clubs Open Day – surveyed 77 residents – 54% aware of Policy. 69% support Policy **Physical Activity** - Multicultural Health week – 350 participants in trying different activities. 8 groups subsidise to attend leisure centre - PA Forum – 40 workers 100% state worthwhile, 45% found new partners - PA Network established - Community Garden scoped **Advocacy** - Community Health strategic plan	Health 30K FCC 30K	Award for best State policy by National Heart Foundation – Smoke-free sporting fields and playgrounds Hospital withdraws from the Partnership Briefing paper developed - New direction for health and council - Establish model of operation - Planning reference group - Annual review

Timeline	Detail	Partners	Priorities	Activities	Budget Resources	Evaluation findings / Notes
				- HP Strategic Plan 2006-2011 - FCC ageing strategy, City Plan and Social plan		
July 2007 2008 2009 June 2010	MOU covers period from 1July 2007 – 30 June 2010 CPO - 21hr per week Executive TOR Work plan – project teams Introduced Strategic Working Group	*Sydney South West Area Health Service:* Director Population Health, General Manager Community Health. *Fairfield City Council* Mayor, City Manager; Manager, Policy and Community Development, Director City Outcomes	**Strategic** - Joint Planning - Sharing information - Gap and strategy development - Emerging trends - Adding value to existing initiatives **Projects** - Physical Activity - Tobacco - Evaluation	**Physical Activity** - Transport Guide - Cycling Project – bike paths / WSCN - Ride to work - PA web database - OOSH – train the trainer **Tobacco** - Puff free parks - Smoke free – hospitals - Clubs open day - Media / marketing - World np tobacco day -	Health 15K FCC 15K Health 30K FCC 30K Health 30K FCC 30K Health 15K FCC 15K	Review – consultant – surveyed members - Organisations can work together and achieved objectives - SWOT Positive findings - Achievements for project delivery - Organisations working together - Input from staff and executive good. What needs work - Opportunities for strategic planning - Managing complexity in health structure - Dealing with competing priorities - Clarity on achieving objectives within existing resources - Equal input - How do we evaluate the 'value' of what we do 2007-2010 – demonstrated capacity for partner's organisations to collaborate and deliver projects. Next phase for 2010-2013 should have a greater focus on strategic planning 2008 – Poster presentation "sustainable partnerships through time and change" Health Promotion Conference – 11 step for partnerships 1. Understand who is on the team and why 2. Take time to discuss the needs of

Timeline	Detail	Partners	Priorities	Activities	Budget Resources	Evaluation findings / Notes
						participants 3. Develop a model: who, what, how, why and when 4. Establish a supportive framework including senior staff 5. Build in the budget 6. Establish explicit rules 7. Invest in your people 8. Understand political environment 9. Be realistic about what can be achieved 10. Take time to reflect and ensure you are on track 11. Seize on opportunities that may arise
July 2010 2011 2012 June 2013	MOU covers the period from 1 July 2010 - 30 June 2013 CPO - 21hr per week Executive TOR Work plan Introduced Strategic Working Group	**Executive Committee** *Sydney South West Area Health Service:* Director Population Health; Director, Health Promotion Service; Strategic Partnerships Program Manager *Fairfield City Council* Mayor; City Manager; Executive Director Outcomes; Manager Policy and Community Development; Senior Policy Advisor (Social, Health & Housing)	**Strategic** - development of collaborative initiatives - sharing of information - identifying and utilising opportunities to gather data on emerging health trends/ issues - adding value to initiatives or issues **Project** - Healthy Food Environments - Smoke Free Environments - Physical Activity	**Health Food Environments** - Nutrition Policy - Audit FCC **Smoking Free Environments** - Puff Free Parks Policy and Implementation **Physical Activity** - Outdoor Gyms Program - Measure Up Campaign - HCI project - Fairfield Health Framework developed 2010 - Secured HCI Grant - Linked health to the Bonnyrigg Redevelopment - Input into health urban development checklist - Input into FCC IP&R documentation	Health 30K FCC 30K Health 30K FCC 30K Health 30K FCC 30K Health 30K FCC 30K	

Timeline	Detail	Partners	Priorities	Activities	Budget Resources	Evaluation findings / Notes
July 2013 June 2014	MOU July 2013 – 30 June 2014	*Sydney South West Area Health Service:* Director Population Health; Director, Health Promotion Service; Strategic Partnerships Program Manager *Fairfield City Council* Mayor; City Manager; Executive Director Outcomes; Manager Policy and Community Development; Senior Policy Advisor (Social, Health & Housing)	Review the Fairfield Health Partnership		Health 30K FCC 30K	
July 2014 2015 2016 June 2017	MOU covers the period from 1 July 2014 - 30 June 2017 CPO - 21hr per week Executive TOR Work plan Introduced Strategic Working Group	**Executive Committee** *Sydney South West Area Health Service:* Director Population Health; Director, Health Promotion Service; Strategic Partnerships Program Manager *Fairfield City Council* Mayor; City Manager; Executive Director Corporate Governance; Group Manager Governance and Community, Manager Social Development	**Strategic** - development of collaborative initiatives - sharing of information - identifying and utilising opportunities to gather data on emerging health trends/ issues - adding value to initiatives or issues **Project** - Integrated strategic planning, policy development and program delivery - Reduce smoking related harm - Support the development of environments to promote healthy eating and active living	Reduce Smoking Related Harm - Tobacco action plan - Puff Free Parks - Education - Advocacy Health Environments - Active Transport signage - Walking and cycling - Health Food Policy - Gyms in Parks - Go4Fun - Audit Tools availability of facilities	Health 38K FCC 38K Health 38K FCC 38K Health 38K FCC 38K Health 38K FCC 38K	

Source: Audit of FCC files (hard and electronic files 1994 – 2016)

Attachment 3 Literature Review

A review of Australian and international literature was undertaken in order to illustrate the characteristics of effective HPS (process) as well as the impacts partnerships have been evaluated as having on improved health related behaviours, with a focus on early intervention and prevention (outcomes). The literature review:

- Defines key terms used throughout the literature;
- Analyses the characteristics of effective health promotion partnerships (process);
- Synthesises and critiques methodologies for evaluating the effective HPS;
- Presents the key findings regarding the effectiveness of partnerships on improving health related behaviours (impact), especially in a LG context; and considers the
- Implications of the findings, while making recommendations to inform the FHP evaluation.

METHODOLOGY

The intent of the literature review is to undertake an assement of peer reviewed academic literature in order to clarify the elements of effectiveness in HPS.

Search Strategy

A variety of keyword descriptors were used in searching online databases search term of health promotion partnerships, HP, collaborative HP, health alliance, effective HPS, joined up governance, collective impact and LG health promotion partnerships.

A total of seven databases were searched for publications from 2000 through to the present (2016), with key articles obtained primarily from PUBMED /public health, MEDLINE, HEALTH-STAR, Healthcare management forum - SAGE Journals Online, Health Promotion Journal of Australia, International Journal of Public Administration and Cochrane Public Health Library. Additional articles were also identified throughout the reading and explored as part of this literature review. These articles were also obtained via the UTS Library.

Inclusion Criteria

The following inclusion criterion was considered to narrow the literature review:

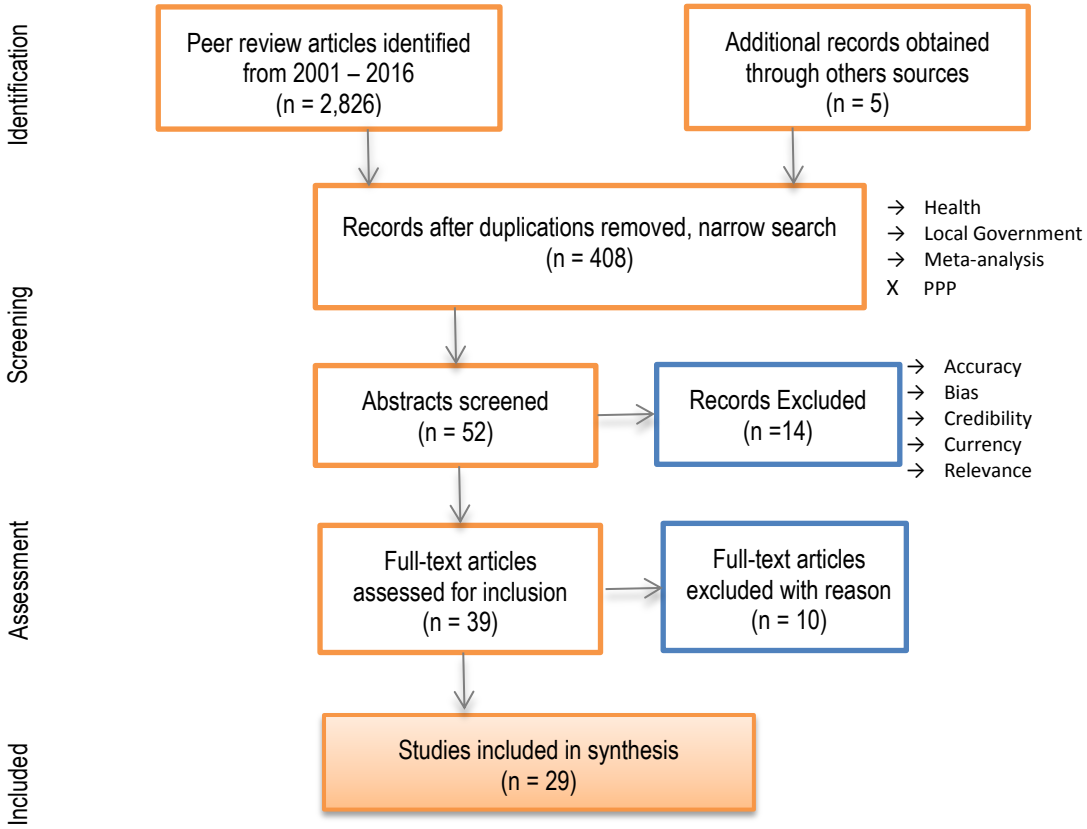
- Initial searches were limited to systematic and meta-analysis reviews however were later extended to include narrative reviews.
- Included international perspectives including US, UK, Canada and Australia.
- HPS which focused on early intervention and prevention.
- A particular focus was placed on studies or reviews conducted within a LG context.
- An evaluation of the model had been carried out.
- Published since 2000.

Exclusion Criteria

The following were excluded from the literature review:

- Public Private Partnerships.
- Articles where partnership primarily involved grants or funding.
- Poor quality methodology (accuracy, bias, credibility, currency and relevance).

Figure 1 Search Strategy



Results of Literature Search

In all, 2,826 references were identified from the searches and five more from additional sources, of which 408 abstracts were reviewed. The full texts of 52 papers were read of which 14 were excluded. Twenty-nine papers were included in the final review (Attachment 1). The majority of studies (n=24) evaluated effectiveness of HPS (process) while only five articles touched on health. In addition, reviews of six tools, which assess the effectiveness of partnerships, were also appraised which informed the methodology for the evaluation of the FHP. This literature review describes the models of joint working and the evidence of their effectiveness before considering what the literature tells us about the factors promoting and hindering joint working.

LITERATURE REVIEW – RESULTS

There is no shortage of theoretical frameworks on how to do partnerships (Dowling *et al* 2004). The initial investigation identifies a plethora of international tools which outline how best to establish and facilitate a HP, however few if any, evaluate the cost or changes to health behaviours (Watson *et al* 2000). Partnerships vary in form, goals and membership and are driven by a common realisation:

> *… that, in today's environment, most objectives related to health cannot be achieved by any single person, organisation, or sector working alone (*Lasker *et al 2001:179).*

Foundations of Effective Partnerships - Process Evaluation

Determinants of successful HPS are those factors which influence the ability of a partnership to combine the perspectives, resources and skills to produce desired outcomes. Determinants of effective partnerships may act as enablers of or barriers to successful partnerships.

Hayes *et al* (2002) suggest that partnerships between health and LG are considered best practice, finding value with the participatory and broad based processes. Mitchell *et al* (2000) identifies three key elements to successful partnerships as being ownership, contractual relations or alliances and informal interaction, identifying that trust and reciprocity were the underlying foundation to successful partnerships. Graham *et al* (2015) identifies four areas where partnerships have been most effective being: fostering knowledge exchange; facilitating community based research; moderate behavioural change; and capacity building and improving resources. Asthana *et al* (2002) determined that a key outcome of partnership was the progress made in terms of shared principles, knowledge and understanding, however evidence on how best to generate organisational change is lacking.

The literature identifies numerous factors to predict the success of partnerships. These include: power and control commitment; trust; resource sharing; managerial commitment; clear communication and agreed deliverables. The Martin-Misener and Valaitis (2008) framework identifies three types of determinants that influence the success of partnerships systemic, organisational, and interpersonal.

Table 3 provides an overview of positively associated factors of effective partnerships identified in the literature. Four themes were identified which provide an indication of success: Governance capacity, organisational capacity, individual capacity and achievement and accountability capacity. For effective integration, research has found that partnerships must happen at *'multiple levels and be supported by a range of cultural and structural interventions which are most effective when they are supported by change at multiple levels, from strategic political commitment throughout collaborative practitioner relationships at the street level'* (Carey & Crammond 2016:1022). The most recognised foundations of effective partnerships which were identified in more than six articles, in order of importance were Shared Vision; Commitment; Trust; Power & Control; Communication; Shared Resources; Evaluation, Relationship and Leadership as outlined in Table 3.

Table 3 Characteristics of effective HPs

Foundations	Supporting Studies	#
GOVERNANCE CAPABILITY		
Policy	Koelen *et al* 2012; Leung *et al* 2016; Martin-Misener & Valaitis 2008	3
Resources and funding	Cameron *et al* 2014; Koelen *et al* 2012; Weiss *et al* 2002; Martin-Misener & Valaitis 2008; Zakocs & Edwards 2006	5
Power & Control (Turf)	Andrews & Entwistle 2010; Bryson *et al* 2006; Cameron *et al* 2014; Carey & Crammond 2015; Oliver *et al* 2016; Riggs *et al* 2013; Martin-Misener & Valaitis 2008	7
Contract arrangements	Mitchell *et al* 2000; Carey & Crammond 2015; El Arifeen *et al* 2013	3
Political, Managerial and staff Commitment	Powell and Gendinning 2002; Bauld *et al* 2010; Cameron *et al* 2014; Flood *et al* 2015; Gills *et al* 1998; Koelen *et al* 2008; Koelen *et al* 2012; Leung *et al* 2016; Riggs *et al* 2013; Weiss *et al* 2002; Bryson *et al* 2006; Carey & Crammond 2016	12
Membership/ ownership / – right people	Atkinson 2005; Dowling *et al* 2004; Koelen *et al* 2008; Mitchell *et al* 2000; Zakocs, & Edwards, 2006; Mitchell *et al* 2000	6
ORANISATIONAL CAPABILITY		
Shared Vision / Agree Objectives / Participatory	Asthana *et al* 2002; Bauld *et al* (2010); Atkinson 2005; Cameron *et al* 2014; Flood *et al* 2015; Gills *et al* 1998; Koelen *et al* 2008; Koelen *et al* 2012; Mabery *et al* 2012; Mitchell	13

decision making	*et al* 2000; Oliver *et al* 2016; Martin-Misener & Valaitis 2008; Zakocs, & Edwards, 2006	
Shared Resources / Expertise / Delivery	Bauld *et al* 2010; Graham *et al* 2015; Powell & Glendinning 2002; Koelen *et al* 2012; Mabery *et al* 2012; Mitchell *et al* 2000; Martin-Misener & Valaitis 2008; Flood *et al* 2015	8
Knowledge Exchange	Graham *et al* 2015; Asthana *et al* 2002; Graham *et al* 2015; Oliver *et al* 2016; Martin-Misener & Valaitis 2008	5
Leadership	Atkinson 2005; Carey & Crammond 2015; Leung *et al* 2016; O'Donnell 2012; Weiss *et al* 2002; Martin-Misener & Valaitis 2008; Zakocs, & Edwards, 2006	7
Dynamics / relationship / Flexibility / Differences/ cohesion	Atkinson 2005; Mabery *et al* 2012; Cameron 2014; Koelen *et al* 2012; Cameron *et al* 2014; Leung *et al* 2016; Mitchell *et al* 2000; Zakocs, & Edwards, 2006; Dowling *et al* 2004	9
Clear roles & responsibilities	Cameron *et al* 2014; Koelen *et al* 2008; Koelen *et al* 2012; Atkinson 2005	4
INTERPERSONAL CAPABILITY		
Trust, respect and transparency	Rummery 2002; Bauld *et al* 2010; Mitchell *et al* 2000; Bryson *et al* 2006; Cameron *et al* 2014; El Arifeen *et al* 2013; Koelen *et al* 2012; Oliver *et al* 2016; Riggs *et al* 2013; Dowling *et al* 2004	10
Culture , Beliefs and Attitude	Koelen *et al* 2012; Asthana *et al* 2002; Graham *et al* 2015; Mitchell *et al* 2000	4
Communication	Bauld *et al* 2010; Cameron *et al* 2014; Flood *et al* 2015; Koelen *et al* 2008; Leung *et al* 2016; Oliver *et al* 2016; Riggs *et al* 2013; Martin-Misener & Valaitis 2008; Zakocs, & Edwards, 2006; Lasker *et al* 2001	10
ACHIEVEMENT & ACCOUNTABILITY CAPABILITY		
Public Value (Change)	Andrews & Entwistle 2010; Bryson *et al* 2006; Leung *et al* 2016; O'Donnell 2012	4
Evaluation, cost – effective, risk vs reward	Atkinson 2005; Mabery *et al* 2012; O'Donnell 2012; Weiss *et al* 2002; Bryson *et al* 2006; Flood *et al* 2015; Leung *et al* 2016; Andrews & Entwistle 2010; Rantala *et al* 2004	9

The discussion below briefly describes the foundations of effective partnerships before summarising the ways in which they enable or form barriers to successful partnerships.

Governance Framework

- Commitment: - was identified in twelve articles and appears to be most effective when partnerships are supported at multiple levels. Strategic commitment from politicians was universally regarded as key (Carey & Crammond 2016) with an emphasis that partnerships must capture 'politicians' interest' and sustain 'political visibility' (Gilles 1998) to gain and maintain support from elected officials. To address this challenge, Koelen *et al* (2008) suggest that partnerships should not just focus on health outcomes but also on short-term and immediate changes. While evidence supports commitment at multiple levels is also important.

  Commitment from management is critical; there is limited drive for individuals to changed entrenched cultures and ways of working, yet workers autonomy enables siloed working practices to be broken (Carey & Crammond 2016).

- *Power & Control (Turf): - Relationships between partners is recognised as a critical factor for successful collaboration. Key features of interpersonal relationships that foster collaboration include trust, respect and creating a fun environment (Koelen* et al *2012; Lasker* et al *2001). Trust and respect between professionals and organisations is essential to the success of partnerships (Cameron* et al *2014). Partnerships are more likely to succeed when they build in resources and strategies for dealing with power imbalances and shocks, as power inequities are a source of mistrust and therefore a threat to successful partnerships (Bryson et al 2006). By their very nature, partnerships bring together professionals and organisations with different*

philosophies and values (Cameron et al 2004) with separate entrenched bureaucracies (Martin-Misener & Valaitis 2008). Power imbalances become most significant when partners have difficulty agreeing on a shared purpose (Koelen et al *2012).*

Organisational Capability

- *Shared Vision*: - Failure to clearly define the values and mission can create tension between partners and reduce the effectiveness and sustainability of the partnership (Koelen *et al* 2008; Lasker *et al* 2001). Effective partnerships require a shared jargon-free (Lasker *et al* 2001) vision for change, including a shared understanding of the problem and shared approach to solving (Flood *et al* 2016).

  Developing governance arrangements that formalise membership, how partnerships make decisions and undertake their work shapes the extent to which perspectives, resources, and skills can be combined (Lasker *et al* 2001). Koelen *et al* (2008) finding show that partnerships can succeed if participants agree on the problem, the aims and objectives, the roles and responsibilities and the strategies and procedures.

- *Shared Resources:* - Partnerships are created by making use of each partner's strengths while finding ways to minimise and overcome characteristic weaknesses. Playing to the strengths of the different sectors seems logically to establishing effective partnerships (Bryson *et al* 2006) because partners contribute what they are good at (Keolen *et al* 2012). Shared funding and sharing resources in relation to information, funding, human and technical resources has been widely highlighted as a way of increasing partner involvement in partnerships (Koelen *et al* 2012; Roussos and Fawcett 2000).

  Enabling top-down and bottom-up strategies to operate simultaneously requires decentralised control. While management are important to set priorities and push through a joined-up culture, relations on the ground may be more important in the long run (Carey & Crammond 2016).

- *Leadership:* - Strong leadership at all levels emerges from the literature as essential for successful partnerships. O'Donnell (2012) argues that leaders in multidisciplinary partnerships require different skills than traditional leaders. The need for strong leaders at all levels emerges from the literature, as successful partnerships are characterised as having:

  > *"leaders who worked to create a supportive, trusting culture conducive to problem solving, where staff are free to find 'work-arounds' to problems (Carey & Crammond 2016:1024).*

  Partnerships 'need boundary-spanning leaders' who can 'understand and appreciate partners different perspectives, can bridge diverse cultures, and are comfortable sharing ideas, resources and power' (Lasker *et al* 2001:193). The literature highlights the leader is an architect rather than a delegator, showing the importance of combining perspectives and producing partner buy-in (Lasker *et al* 2001; Roussos and Fawcett 2000).

- *Relationships:* - Successful partnerships depend on the level of engagement and commitment of the partners (Dowling *et al* 2004). The relationship between partners was identified as an overriding factor of the success of partnerships (Keolen *et al* 2012) as partners bring personal characteristics and opinion, that is attitudes, beliefs, self-efficacy, social identity and personal relationships (Dowling *et al* 2004). Communication between parties work best when there is a combination of formal and informal communication. Conversely, disliking partners, on a personal level, makes partnerships burdensome and ineffective (Koelen *et al* 2011).

Individual capability

- *Trust*: - Successful partnerships involve high levels of trust, reciprocity and respect between partners (Dowling *et al* 2004). Partnerships are more likely to succeed when trust-building activities, common bond and sense of goodwill are constant (Bryson *et al* 2006). Mitchell & Shortell (2000) identify the three major mechanisms as ownership; contractual relations or alliances; and informal interactions are characterised by norms of trust and reciprocity. Partners build trust by sharing information and knowledge, exhibiting competency, good intentions and follow-through (Bryson *et al* 2006).

- *Communication*: - Effective communication strategies and mechanisms to facilitate partner activities are needed to synergise thinking and action. (Lasker *et al* 2001). Developing effective communication between partners was identified as a key challenge, due to the nuanced understanding of differing demands, language and culture (Riggs *et al* 2013). Partnerships require an open-minded approach, actively learning and innovative organisations that are willing to go beyond the normal, where resolved conflict can lead to a stronger relationship through improved communication (Koelen *et al* 2008).

Achievement and Accountability Capacity

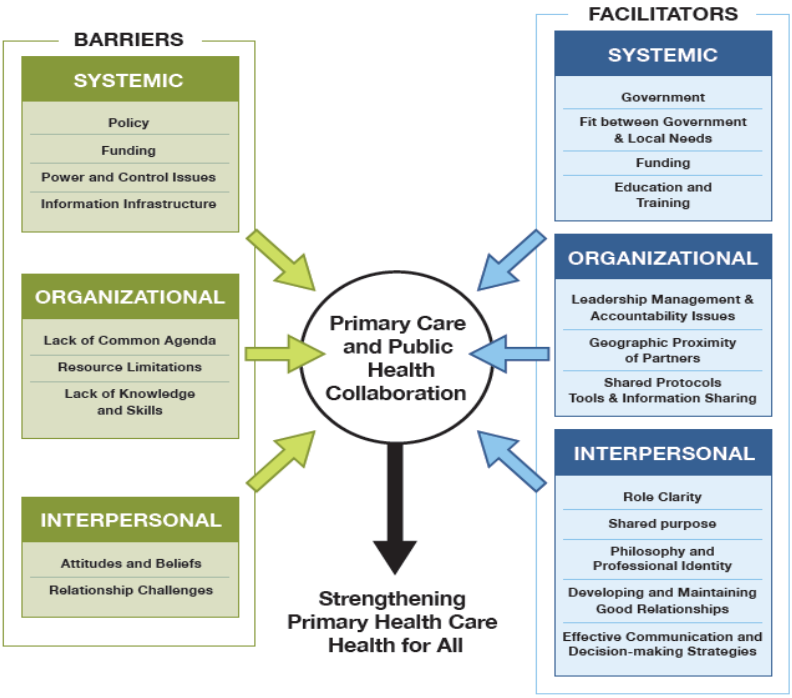
- *Evaluation:* - Measurement and evaluation of partnership activities is cited in the literature as a key factor to the success and sustainability of partnerships. Bryson *et al* 2006 argues that the purpose of partnerships is to produce 'public value' that cannot be achieved by a single organisation. It is impossible to know whether your partnership has been success unless you have evidence of a change and it necessary for gaining political and managerial support (Roussos and Fawcett 2000). Rantala *et al* (2014) found that a lack of baseline data was frequently cited as a challenge for evaluation.

Barriers to effective partnerships

Elements of effective partnerships are dominant within the literature with the barriers to partnership working being numerous and varied. The four most commonly identified barriers were funding, time, turf and trust (O'Donnell 2012; Norris-Tirrell Clay 2010; Martin-Misener and Valaitis 2008). In addition Norris-Tirrell Clay (2010) claim that a muddled sense of authority and delegation results in questions of ownership, frustration, and leads to paralysis (Norris-Tirrell and Clay 2010).

Other barriers identified in the literature include a lack of common agenda, limited resources and lack of role clarity (Martin-Misener & Valaitis 2008), poor communication and differences amongst partner organisations with respect to culture, beliefs, structures and commitment (*Mabery et al 2012*). Martin-Misener and Valaitis (2008) model of interactive barriers and facilitators, as outlined in Figure 2 demonstrates the interrelationship between enablers and obstacles to effective partnerships.

Figure 2 Barriers and facilitators to effective partnerships



Source: Martin-Misener & Valaitis (2008)

Health Impacts – what the evidence tells us?

It is often claimed that partnerships should be measured in terms of their health outcomes rather than the processes. It is widely accepted from international studies that there is a lack of tangible evidence to support that HPS has any effect on health (Rummery *et al* 2002; Rousos *et al* 2000; Graham *et al* 2015).

Graham (2015) describes flexibility and responsiveness as one of the greatest assets, which shape the underpinnings of HPS, however this presents a quandary for researchers. Only a few articles have focused on the effective HPS and there is no reliable evidence that partnerships necessarily improve health related behaviours (Hayes *et al* 2012; Dowling *et al* 2004; Graham 2015; Rousos *et al* 2000; and Martin-Misener and Valaitis 2008).

Hayes *et al* (2012) findings did not identify any reliable evidence that interagency collaboration, compared to standard services led to health improvement, concluding that only one study showed a modest improvement, that may have been a result of significantly more resources (Hayes *et al* 2012). Rousos *et al* (2000) concluded that there was insufficient evidence to make strong conclusions about the effect of partnerships on population-health outcomes, with Schoen *et al* 2014 finding that further research was required to define the causal linking between partnerships and its relationship to health outcomes, with Rummery *et al* (2002) longitudinal studies also showing little evidence of any changes to health.

The reason for the lack of evidence is partly due to a number of challenges associated the environment. Firstly, empirical studies have failed to make any causal link between HPS and health outcomes (improved health or quality of life). It has been recognised that measurable health need to be measured in the long term which may be difficult to attribute to the partnership. Secondly, it is difficult to assess the counterfactual, such as what might have transpired in the absence of the partnership (Dowling *et al* 2004). The program Logic Model (Attachment 1) shows the inputs, outputs and changes to health related behaviour to be evaluated.

Health Partnerships - Evaluation Tools

There is a plethora of tools to assess the effectiveness of partnerships which provide guidance for the evaluation of the FHP. Following partnership tools identified in the literature which have been reviewed and inform the methodology of the FHP research proposal. The tool selected have been developed and tested and have their foundations established in evidence based approaches.

The **Centre for Disease Control and Prevention's Partnership Evaluation Guidebook** provides a step by step guide to evaluating HPS, clarifying approaches to methods of evaluation. The Guide provides several examples and tools which are applied to case studies to demonstrate applicability. The Guide primarily focuses on a survey methodology to measure effectiveness (CDCP 2011).

The **Centre for the Advancement of Collaborative Strategies in Health's Partnership Self-Assessment Tool** assesses how well its partnership process is working and identifies areas for improvement. The Partnership Self-Assessment Tool was developed using the Partnership Synergy Framework (Lasker, *et al* 2001) to provide a measurement of the key indicators for successful collaboration and level of synergy. The Tool consists of 67 questions covering 11 topics using a Likert scale and/or yes and no questions. Topics include synergy; leadership; efficiency; administration and management; on-financial resources; financial and other capital resources; decision making; benefits of participation; drawbacks of participation; benefits and drawbacks of participating in the partnership; and satisfaction with participation. The tool has been evaluated for validity and reliability (CACSH 2002).

The ***Canadian Coalition for Global Health Research's*** **Partnership Assessment Toolkit** is an evidenced based Tool composed of a series of questions to measure HPS through four stages: Inception, Implementation, Dissemination and "Good endings and new beginnings". The tool is focused on the process of HPS (Afsana *et al* 2009).

The Verona Benchmark is a management tool that has being piloted in 15 sites across Europe which measures the effectiveness and the quality of partnerships. The Tool uses a series of self-assessment questions covering 11 elements aimed to assess the strengths and areas for improvement in a partnership (Watson *et al* 2000).

These tools along with the research finding have informed the research proposal and methodology for the evaluation of the FHP as described in Attachment 3.

DISCUSSION

All the articles reviewed as part of this literature search identified the need for sounder evidence to justify and prove the effectiveness of HPS. Much of the research into partnerships centres heavily on process issues, while little emphasis has been given to outcome success. A constant theme throughout the literature was the difficultly and challenge of evaluating within the broad influencing social environment of health. If social welfare policy is to be more concerned with improving service delivery and user behaviours, than with the internal mechanics of administrative structures and decision-making, this is a knowledge gap that urgently needs to be filled (Dowling *et al* 2004).

Many argue that the lack of evidence is due to the difficulty in evaluating structures and collaborations (Schoen *et al* 2004), and that continued investment in research on partnerships is required. Dowling *et al* (2004) identified the need to broaden the research to include analysis of the cost effectiveness of partnerships including potential disadvantages of delay and additional cost, suggesting that measuring short and medium term behaviour changes may be more effective, avoiding the challenges of measuring and attributing health outcomes over the longer term.

There is no doubt that the lack of evidence is partially due to the difficulty with evaluation methodologies. As suggested by Bauld *et al* (2010) evaluating the complexity of HPS is complex and challenging, arguing that 'primacy of experimental approaches for evaluation is often inappropriate' for social interventions. Bauld *et al* (2010) offers an alternative evaluation methodology whereby suggesting a triangulation approach be adopted to measure the complex links between activity and contexts of the partnership.

The proposed methodology for evaluating the FHP, there focuses on the short (process) an intermediate health related behaviours (impact) as outline in Attachment 1 and 3).

Factors affecting the validity of these conclusions

Based on literature, several cautions must be voiced before any firm conclusions can be drawn. The literature examined a wide range of factors of effective partnerships (n=29) but few measured (n=5) actual changes in health behaviours. The literature identified a wide range of partnership building factors which were groups based on related characteristics.

While, articles were selected on available meta-analysis records, the majority of articles identified significant limitations, due to the lack of rigour in the initial evaluations. This may be in part be due to the difficulty in measuring the effectiveness of HPS, ability to attribute outcomes in uncontrolled environments and principally due to the fact, that many research articles have a limited timeframe and are often too recent for definitive conclusions to be drawn on changes to health and behaviours.

In undertaking this review, some significant gaps in the published literature on the effectiveness of HPS became apparent with little literature exploring its impact on health outcomes.

Conclusion

In closing, community partnerships have become an entrenched strategy within the health promotion arena. The current literature provides some consensus on evidence-based coalition-building factors which identified four overarching themes being Governance Capacity, Organisational Capacity, Individual Capacity and Achievement and Accountability Capacity with the foundations of effective partnerships ensuing Shared Vision; Commitment; Trust; Power & Control; Communication; Shared Resources; Evaluation, Relationship and Leadership.

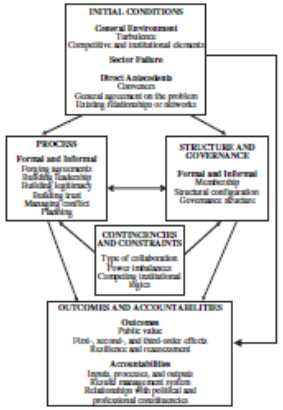
Decades of research on the impact of partnerships between health and LG has shown that there is no reliable evidence that partnerships have any effect on health outcomes (Rummery et al 2002; Rousos et al 2000; Graham et al 2015). The reason is partly due to a number of challenges including (Dowling et al 2004):

- empirical studies have failed to make any causal link between HPS and health outcomes (improved health or quality of life);
- measurable outcomes need to be measured in the long term, therefore attributing change to the partnership is difficult; and
- it is also difficult to assess the counterfactual, such as what might have transpired in the absence of the partnership.

Further research was required to define the causal linking between partnerships and its relationship to health related behaviours. The evaluation of the FHP will overlayed the foundations for effective partnerships with good governance framework to determine the characteristics of effective partnerships as well as measuring any change to health related behaviours.

Author/s	Details	Objectives	Overview	Methodology	Key Findings	Implications
Andrews & Entwistle 2010	UK	Two hypotheses 1. The coefficient for the impact of public-public partnership on effectiveness 2. The coefficient for partnership, by contrast, is actually negative and significant and that for public-non-profit partnership insignificant.	Theories of sectoral difference suggest that the public, private, and non-profit sectors all show unique advantages that can enable them to deliver improvements on core administrative values. Little research has systematically addressed the question of whether the distinctive hypothesized benefits of each sector for effectiveness, efficiency, and equity are realized through cross-sectoral partnership.	Present an exploratory quantitative examination of this argument, using primary and secondary data from 46 UK LG service departments. Surveyed – response rate was good.	The results indicate that partnership is positively associated with effectiveness, efficiency, and equity, but that partnership is negatively associated with effectiveness and equity. The findings support their first hypothesis. The results reveal a positive association between partnerships and public service effectiveness, efficiency, and equity. Conversely, partnership with private sector organizations was negatively associated with effectiveness and equity for our sample of organisations.	This article is not specifically about health related partnership and included Public Private Partnerships as well as public – non-profit partnership. Was included in the literature search to present an alternate approach. The article represents, only an initial template for the quantitative exploration of partnership and performance and has several limitations.
Asthana et al 2002		Applies a multidisciplinary perspective to construct a typology of effective governance and management characteristics of CHPs, based on idea of external and internal alignment.	CHPs indicate that they frequently fail to achieve measurable results. Problems associated with the governance and management of CHPs have been cited as possible reasons for the failure of these organisations to demonstrate significant, measurable outcomes. There is little systematic research on the governance and management of CHPs.	Methodology the paper described in detail the terms used and the elements it considered. Use a modified program logic model to evaluation partnerships. Based on the framework and review of the existing literature, they identified seven relevant aspects that can be used to categorise partnerships.	Show that while the theoretical benefits of partnership have been well practiced, organisations charged with fostering partnerships lacks evidence about how best to proceed in bringing about organisational change. Asthana *et al (*2002)" concluded that a key outcome of partnership was the progress made in terms of shared principles, knowledge and understanding. These would be considered successful processes rather than successful outcomes".	Evaluates the partnership outcomes, however falls short on evaluation the community outcomes.
Atkinson, M 2005	North Ireland	Evaluation the complexities of working in partnership. Assess if collaboration actually adds value in terms of both process and outcomes.	"The key test is whether the extra benefits that come from working in partnership are greater than the costs involved in doing so".	Action Research methodology Literature Review Interviews Data analysis	Atkinson (2005) developed an evaluation framework for partnership working. The framework includes 7 dimensions of performance: 1. *Impact*: extent the partnership has added value and achieved a greater impact than would have been achieved without its existence. 2. *Vision and leadership*: extent to which the partnership has been able to develop a shared and cohesive vision as an outcome of effective leadership. Atkinson identifies attributes of effective leadership similar to those referred to in this resource.	Excellent article Methodology did not clearly outline the number of participants involved.

Author/s	Details	Objectives	Overview	Methodology	Key Findings	Implications
					3. *Partnership dynamics*: extent the partnership has developed appropriate structures, processes, resources and culture conducive to collaboration. 4. *Strategy and performance measurement*: extent to which processes for strategic and performance measurement have been embedded in the partnership and the degree to which they are effective. 5. *Influencing:* extent to which the creation of the partnership has enhanced the joint understanding of the political, organisational and funding context in which the partnership operates and how effectively it influences at different levels to bring about change. 6. *Participation:* extent to which the partnership actively promotes the involvement of target audiences as stakeholders for collaborative action. 7. *Cost-effectiveness:* benefits that come from working in partnership are greater than the costs involved in doing so.	
Ayton et al 2012	Australia	Values of churches have synergies with health promotion.	Gives a historical overview of churches role in health promotion.	Literature search – primarily in the US - historical overview. The findings do not support the assumptions made	The findings show that the Church should be a partner for the government to implement health promotion.	Does not measure the effectiveness of Health Partnerships or the impact on health. Bias – unclear.
Bryson et al 2006	US	*Focuses on cross-sector collaboration that is required to fix complex public problems.*	*Propositional inventory organised around the initial conditions affecting collaboration formation, process, structural and governance components, constraints and contingencies, outcomes, and accountability issues.*	Literature Review	As the propositions presented here indicate, cross sector collaborations are difficult to create and even more difficult to sustain because so much must be in place and work well for them to succeed. 22 propositions – Success factors – more likely to succeed when…… when they combine − deliberate and emergent planning resources and tactics to equalize power and manage conflict effectively. − they build in resources and tactics for dealing with power imbalances and shocks. − have an accountability system that tracks inputs, processes, and outcomes; use a variety of methods − committed sponsors and effective champions at many levels who provide formal and informal leadership" − trust-building activities (such as nurturing cross-sectoral and	Good Article – however methodology for selection is unclear.

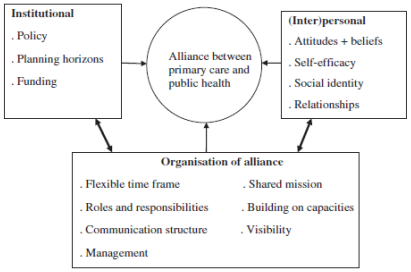
Author/s	Details	Objectives	Overview	Methodology	Key Findings	Implications
				 **Figure 1 A Framework for Understanding Cross-Sector Collaborations**	cross-cultural understanding) are continuous. – create public value when they are resilient and engage in regular reassessments.	
Cameron 2014	UK	Reviews the research evidence and whether reforms to joint working have met the objectives set by policy-makers.	Concluded that while the literature said a lot about the process of joint working, little attention had been paid to exploring the effectiveness. Concluded that literature has barely shifted on from 1970s and early 1990s, most studies still focused on the processes rather than the outcomes of joint working. There is some indication that integration of services may have positive benefits for organisations, users and carers.	Literature Review – meta analysis 46 papers reviewed Age care and joint service delivery in the field of adult health and social care	The evidence reported a lack of understanding about the aims and objectives of integration. OUTCOMES: While greater emphasis has been placed on evaluating outcomes, evidence available was largely small-scale evaluations of local initiatives. Few were comparative in design with differences between 'usual care' and integrated care not assessed. PROCESS FACTORS FOR SUCCESS 1. Organisational Issues - Shared Purpose - Roles & Responsibilities: clear framework - Flexibility - Organisational Differences - Communication and Information Sharing - Co-location – joint working - Management Support - Team building - Adequate resources 2. Cultural / Professional Issues - Professional ideologies and philosophies - Respect, trust and control	Clear state methodology which is sound Excellent article – presented both the limitations and advantages of Partnerships. Reviewed 46 papers – very succinct, well written and thorough literature search. Implications: The joint working approach adopted in the study primarily were established through Government policy – that is a top down approach

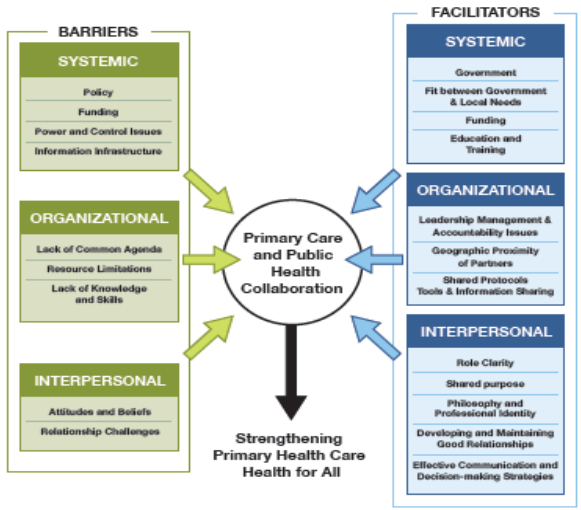
Author/s	Details	Objectives	Overview	Methodology	Key Findings	Implications
					3. Contextual Issues - Relationship and reorganisations - Financial certainty *"Evidence is a reminder that successful integrated services 'cannot simply be created by government diktat', requiring careful design, effective information systems and most importantly, time 'to develop a distinctive organizational culture to develop systemness' (Bevan & Janus 2011, p. 159).* "Integration is no quick fix"	
Carey, G. & Crammond B. 2015	Australia	investigations of joined-up government, and evidence on the process of creating joined-up government	There continues to be no specific body of evidence upon which judgments can be made about the overall success of joined-up initiatives.	Literature Review meta-analysis Peer-reviewed empirical literature in order to detect patterns in what is, and is not, effective. Studies were assessed for quality. Included 15 empirical studies of 26 joined-up initiative case studies.	Identified 5 areas of indication of success: 1. operational level 2. nature of control 3. top/bottom focus, 4. instruments, and 5. membership *"Joined-up initiatives appear to be most effective when they are supported by change at multiple levels, from strategic political commitment throughout collaborative practitioner relationships at the street level"*	Clear methodology
Dowling et al 2004	UK Meta-analysis	Literature search to identify how partnership success is conceptualised.	'*While there is no shortage of theoretical frameworks within which to understand partnerships'* (Holtom 2001, Asthana *et al* 2002, Sullivan & Skelcher 2002) or of guides to successful partnerships (Ling 2000, 2002), evidence of success remains elusive (El Ansari *et al* 2001). It is uncertain whether partnerships work, and therefore, whether they should count. There is no shortage of advice on how to do partnerships (Ling 2000).	The literature theorised the success of partnerships in two ways: (1) Process issues: how well the partners work together to address joint aims and the long-term sustainability of the partnership (2) Outcome issues: changes to service delivery, and effects on the health or well-being of service users. The authors found that	There has been little attempt to consider the benefits and costs of partnerships. Two obvious potential disadvantages are delay and cost which are yet to be explored. Research to date on successful partnerships has largely used qualitative methods and has focused on process rather than outcome issues. Little of the literature addressed the issue of causality in partnerships, even less research considered the costs of partnerships and neither of the studies addressed the questions of cost-effectiveness. Empirical studies that attempted to establish a clear causal link between the partnership and its outcomes, the findings tended to be	Excellent article – presented both the limitations and advantages of Partnerships. Reviewed 36 papers – very succinct, well written and thorough literature search.

Author/s	Details	Objectives	Overview	Methodology	Key Findings	Implications
			'First, there is the problem of defining partnership. Most commentators have concluded that there is no clear and uncontested definition' (Miller & Ahmad 2000, Glendinning 2002, Powell & Glendinning 2002, Sullivan & Skelcher 2002).	research into partnerships centres on process issues rather than outcome success.	inconclusive. Concluded that there was, nevertheless, a lack of firm and consistent evidence that positive outcomes had been achieved by the partnerships concerned.	
El Arifeen et al 2013	Bangladesh	Link health outcome to Bangadesh's approach to health care.	Three features in Bangladesh's over the past four decades: 1. application of community health workers at scale; 2. partnerships between the government and non-state organisations; and 3. early and rapid implementation of innovations. NGOs engaged at three levels: 1. national EPI office - provided technical assistance on training, program support and monitoring, and community mobilisation; 2. they provided program management and monitoring support to managers; 3. community level for community mobilisation and promotion of attendance at outreach sites. Partnership types 1. collaborative partnerships – shared objectives and agreed roles. 2. contractual partnerships- government completely outsources	Literature search on health-service delivery in Bangladesh published between 1970 and 2012. Focus on primary health care and the family planning, tuberculosis, and oral rehydration therapy and Immunisation. Scholar for peer-reviewed articles Also undertook quantitative analysis of available date in comparison to 4 countries,	Explore strategies in health-service delivery that have maximised reach and improved health outcomes. Identify three distinctive features that have enabled Bangladesh to improve health-service coverage and health outcomes: 1. large-scale community-based approaches, especially investment in community health workers using a doorstep delivery approach; 2. informal and contractual partnership with NGO's to generate community trust, reach the most deprived populations, and address service gaps; 3. rapid adoption of context-specific innovative technologies and policies that identify country-specific systems and mechanisms.	Great attempt at linking outcomes to partnership, however more analysis of the data and comparisons is need. Also an issue with causation. It is unclear which intervention achieved the identified outcomes. Figure 1 compares a number of health indicators to 4 other countries. Some of the partnerships were based on grant funding and results may be attributed to additional resources rather than the effectiveness of the partnership. Doesn't evaluate the three identified strategies.

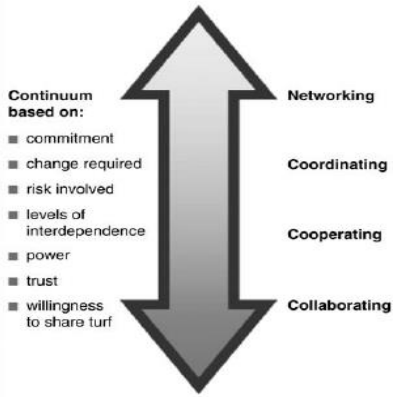
Author/s	Details	Objectives	Overview	Methodology	Key Findings	Implications
			3. informal partnerships, government allows private organisations to provide services that the government does not			
Flood et al 2015	US	Describes the CI model and its key dimensions and constructs - the benefits, challenges, and initial outcomes	Collective impact (CI), an emerging model for creating larger scale change, has yet to receive much study. Discusses several prerequisites for CI's successful application: adequate financial resources, an "influential champion" to engage decision makers and stakeholders across sectors, a "sense of urgency" for change, and an understanding that current approaches are insufficient.	Literature Review and a detailed Case Study	Despite some limitations discussed later, the CI model is gaining adherence in the fields of health promotion and public health more broadly. Core tenets of CI – Common Agenda (Shared) – Standard measurement – Mutually reinforcing activities – Continuing communication – Backbone support **Table 1.** The Collective Impact Model: Phases and Core Tenets. Core tenets / Preconditions / Phase 1: Initiating action / Phase 2: Organizing for action / Phase 3: Sustaining action and impact Common agenda / Sense of urgency for change / → / Creating backbone organization and dedicated staff time and resources / Implementation of tasks and strategies Shared measurement / "Influential champion" to draw in key players / → / Developing common agenda, goals and strategies / Collection, tracking and reporting data and progress; and identifying areas for improvement Mutually reinforcing activities / Understanding limitations of current approaches / → / Build common and public will / Mutually reinforcing activities Continuous communication / Community involvement / Identifying a shared system of measurement for accountability / Continuous communication Backbone support / Use of data to help identify key issues and needs and "make the case" for the new group's work / Cross-sector efforts Continuous communication Mutually reinforcing activities / Accent on innovation and creating new approaches	Single case study is highly limited. Collective impact is a term used to describe partnerships, collaboration. Matrix approach is practical and effective.
Gills et al 1998	UK	Assesses the impact of alliances or partnerships for health promotion	Interestingly, in most of the published accounts, the outcome measures for assessing the effectiveness of community-based alliances or partnerships for health promotion were often measures of individual level changes.	Two way approach 1. a review of the published literature since 1986, using the search strategy of the Cochrane Collaboration. 43 are included in the analysis. 2. involved a global network of health promotion experts identifying current best practice around the world.	Partnerships do work. Durable structures which facilitate planning and decision making, such as local committees and councils, are key factors in successful alliances or partnerships for health promotion. Found that the existence and implementation of policies for health promotion activities were crucial to sustainability.	
Graham et al 2015	Canada	This article aimed to demonstrate that the current level of	Showed a prevalence and enthusiasm for partnerships, however there is limited evidence	Literature search This article presents a review	Unproven: better evidence is required to provide evidence of effectiveness of PHP.	Short article will narrow literature search and finding could be strengthened.

Author/s	Details	Objectives	Overview	Methodology	Key Findings	Implications
		enthusiasm for PHPs in Canada is disproportionate to their demonstrated effectiveness.	and few published evaluations of public health partnerships in the Canadian context. International literature reports that most partnerships have little to no effect on health outcomes. Woulfe *et al* . *"made a strong case for continued investment in PHPs, reporting that the justification for partnerships is still driven by conventional wisdom'' rather than evidence".*	of current PHP literature, focusing on the results of international systematic reviews to provide evidence for Canadian public health decision-makers.	Research has demonstrated PHPs are most effective at (a) fostering knowledge exchange (b) facilitating community-based research (c) achieving moderate behaviour and (d) supporting the provision of public health services when health agencies have minimal resources.	
Hayes et al 2012		Evaluated the effects of collaboration between health and LG agencies on health outcomes.	Identified two quality studies identified, one showed no evidence that collaboration between local services improved health and the other showed a modest improvement in some areas.	Sixteen studies met the inclusion criteria for the narrative synthesis, of which 11 contributed data to meta-analyses.	"Collaboration between local health and LG is commonly considered best practice. However, the review did not identify any reliable evidence that interagency collaboration, compared to standard services, necessarily leads to health improvement".	All 16 articles were reviewed for bias and quality.
Koelen *et al* 2008		Identify factors that are important in achieving and sustaining coordinated action for health.		Authors' experiences with coordinated action in community health promotion and review of literature.	Six factors are identified: 1. representation of relevant societal sectors including clients, 2. discussing aims and objectives, 3. discussing roles and responsibilities, 4. communication infrastructure, 5. visibility and 6. management. *"Getting along well facilitates the willingness to compromise, to share knowledge and expertise and to share work".* *"it is not what people have in common but their differences in view of their expertise, knowledge, capacity and the organisation makes coordinated action more powerful than working separately".*	Characteristics of successful partnerships. Literature review methodology limited.
Koelen *et al* 2012	Europe	Identify prerequisites and conditions of effective	HALL Framework	European Food and Shopping Research Programme, between 1991 and 2000. Eight	The HALL framework identifies three clusters of factors that either hinder or facilitate the success of alliances: 1. institutional factors	

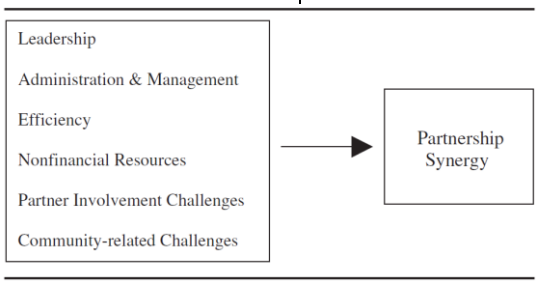
Author/s	Details	Objectives	Overview	Methodology	Key Findings	Implications
		partnerships.		European so-called Healthy Cities participated.	- policy - Planning Horizons - Funding 2. personal factors of participants in the alliance - Attitude and belief - Self-efficacy - Social identity (alignment) - Personal relationship (trust) 3. factors relating to the organization of the alliance - Flexible timeframes - Shares mission - Clear roles and Responsibilities - Building capacity - Visibility - Management	
Leung et al 2016	Ontario, Canada.	Reviews the ability of partnerships to foster inter-agency progress in tackling wicked problems at the intersection of environment and health.	Case examples highlight the advantages and the challenges of diverse partnerships, and the importance of governance and leadership models, scaling up (and out) impact, and cross-cultural communications.	A case example methodology in accordance with literature. Composed of a document review and semi-structured interviews with key informants from five environment and public HP.	Identified 7 salient domains for effective partnerships - policy gaps - leadership - governance - scaling up success - partner diversity - monitoring and evaluation - communication Findings in line with other studies (e.g., Anholt, Stephen, and Copes 2012; Arnstein 1969; Israel *et al* . 2012; Mitchell and Shortell 2000; Schultz, Israel, and Lantz 2003) Importance of partnerships in creating "collaborative advantage"	Good article – provided practical case studies to identify key domains of effective partnerships, which were then assessed against the literature. The article could have provided a better account of the methodology and semi-structure interviews.
Mabery et al 2012	USA Case Study	Assesses the value of communities of practice (CoPs). Measure relationship and identifies barriers to participation or success.	Questions asked of participants: 1. How do members perceive the purpose of the CoP to which they belong? 2. To what extent is each CoP meeting member expectations? 3. What type(s) of outcomes and benefits are associated with	Four communities 37 interviews from 199 random sampled Qualitative interviews	Results showed clear benefits including daily work efficiencies, expanded infrastructure, and enhanced relationships. Barriers were Lack of time and competing priorities Identified the importance of time in the initial stages to share, learn, and build trust before work can begin: developing the critical relationship base that will be needed to share knowledge transparently and work well together to address common problems.	Small qualitative study Methodology clearly stated The paper does not clear demonstrate how it came to reach its findings – other than opinion of members. Descriptive, providing no

Author/s	Details	Objectives	Overview	Methodology	Key Findings	Implications
			each CoP? 4. What are the key success factors for effective CoPs? 5. What factors limit participation in the CoP?			clear data on effectiveness However, provides a unique approach to build upon
Martin-Misener and Valaitis 2008	Canada	To descriptive: structures and processes required to build successful collaboration; outcomes of collaborations; and markers of successful collaboration		Literature Review- 114 met the inclusion criteria		Great article – clear methodology and clearly outlines the evidence from a range of reliable sources.
Mitchell et al 2000	US	Applied a multidisciplinary perspective to construct a typology of effective governance and management characteristics of Community HP	There are many examples of CHPs across the United States. Despite their growing popularity, however, evidence demonstrated that CHPs more frequently fail to achieve measurable results. Identified three major mechanisms: ownership; contractual relations or alliances; and informal interactions characterised by norms of trust and reciprocity. Recent evidence CHP indicates that the level of community	Paper applies a multidisciplinary perspective to construct a typology of effective governance and management characteristics of CHPs, based on notions of external and internal alignment. Meta-analysis	Triangle of strategic alignment of environment capabilities and strategies. The paper identified seven main dimensions of a typology: 1. the nature of the problems addressed 2. partnership composition 3. differentiation 4. coordination and integration 5. accountability 6. centrality 7. alignment The paper suggests that the result is a “high alignment–high	The paper looks at the process of partnerships but fails to review the outcomes achieved from the partnership.

Author/s	Details	Objectives	Overview	Methodology	Key Findings	Implications
			resources or support for the partnership prior to initiation is a critical factor of success.		influence" partnership.	
O'Donnell, O 2012	Australia	Examines collaborations the rationale with international examples	Paper has offers examples of different approaches to strategic collaboration.  	Literature Review Case Studies	Identifies a series of steps in developing effective partnerships. Six principles of strategic collaboration practice 1: Choose strategic collaboration wisely. 2: Understand the strategic collaboration lifecycle. 3: Strengthen leadership capacity. 4: Balance risk and reward transparently. 5: Cultivate innovation for meaningful change. 6: Emphasise outcomes and impacts. *Norris-Tirrell and Clay (2010:319)*	Presents a narrative of case studies of collaborations describing the elements of partnership. However, doesn't provide an evaluation and assumptions. Links back literature
Oliver et al 2016	Several countries	Narrative review of the literature: identifying benefits and challenges of NGO–R partnerships	NGO–R partnerships provide opportunities for partners to learn from each other, and draw upon each other's skills and expertise.	Literature published between 1998 and 2015 with case studies from NGO-R partnerships. Methodology for case studies is unclear.	Identifies four key approaches: 1. Improving communication between partners; 2. Promoting transparency in decision-making; 3. Enhancing respect and solidarity among partners; and 4. Building a partnership characterised by trust. The results suggest that collaborations characterised by trust, transparency, respect, solidarity, and mutuality contribute to the development of successful and sustainable NGO–R partnerships. Identified the following elements: Mutual learning, Improved knowledge, Increase access to community, Equality of partnership, Communication, Transparency in decision-making, Respect and Trust	Case studies provided are poor and the authors make allegations which are unsupported by evidence provided. They provide some links to evidence – which could be improved. However elements identified are consistent with the research.
Rantala et al 2015		The study identified cases of LG ISA identifying challenges and	The literature identified features of ISA, such as monitoring and evaluation and health equity. Evidence was found to be comparatively thin.	A total of 25 cases were included in the review from across the world.	Research literature was found to be thin, particularly on facets of local-government ISA such as evaluation, monitoring and equity issues. There was little evidence on any long-term efficiency of ISA on	Limitations were identified such as depth of information and often focused on the point of view of one sector in some articles reviewed.

Author/s	Details	Objectives	Overview	Methodology	Key Findings	Implications
		facilitating factors			health outcomes, but it is valuable as a participatory and broad-based process.	
Riggs et al 2013	Australia	Provides insights into how to evaluate inter-agency partnerships	1. Demonstrate how partnership evaluation methods can be adapted to provide insights into partnership processes. 2. Present empirical findings of staff perspectives of the challenges and enablers of the inter-agency partnership.	Brinkerhoff's evaluation framework - using a mixed method longitudinal approach 1. organisational ethnographic approach; 2. partnership checklist surveys (n=15 and 16); and 3. Semi-structured interviews. (n= 15 and 25).	"*Partnership evaluation research in Australia has been limited with few studies reported in the peer-reviewed literature".* Key themes - Trust identified – also supported in international literature (Calnan and Rowe, 2008; Lester *et al* 2008). - Mutual respect - Effective communication - – also supported in international literature (Teel *et al* 2011). 	Excellent paper which provides evidence framework in practice. Literature review is broad and comprehensive. The findings are process orientated and findings need to be better attributed.
Rousos et al 2000	US	Explores the evidence that partnerships can effectively transform conditions to improve health-related behaviours and more distant population-level health outcomes? 1. community and systems change	Identified two broad deductions on collaborative partnerships for community health improvement: collaborative partnerships have become an increasingly popular strategy, and only limited empirical evidence exists on their effectiveness in improving community-level outcomes.	10 of the 34 reviewed studies presented population-level outcomes with some improvements that could be potentially attributed to activities of the collaborative partnership.	Altogether, findings are insufficient to make strong conclusions about the effects of partnerships on population-level outcomes. The results suggest at least under some conditions, implementation of collaborative partnerships will result in improvements in population-level health outcomes.	Well written and comprehensive. Describes both advantages and limitations of the article. Reviewed 34 peer review articles. Many limitations to the studies used were identified.

Author/s	Details	Objectives	Overview	Methodology	Key Findings	Implications
		2. community-wide behaviour change, 3. more distant population-level health outcomes.				
Rummery et al 2002	UK	Tracks development of partnership between the new primary care organisation	Literature review was limited.	3-year longitudinal survey and an annual in-depth qualitative study of partnership working at the strategic, managerial and operational levels.	Progress towards partnership working between the new PCOs and local authorities has been variable over the first couple of years of their existence. Showed a lack of tangible benefits to date for users and carers, there is little evidence to show that welfare users benefit significantly from Partnerships	Methodology was sound – did not detail and limitations to the methodology.
Schoen et al 2014	US	Measuring the effectiveness of partnerships	While partnerships are popular approaches, there is a lack of evidence on the effectiveness and impact. Reason for lack of data is the difficulty in evaluating structures and collaborations.	Collected data from 23 projects. Social network analysis techniques to measure. 405 contacted to participate across 23 communities. 83% response rate.	Further research is required to define the causal linking between partnership and its relationship to health outcomes.	Did not define partnerships. High response rate. Evaluated partnership not the health outcome. Discussed limitations – sample size good.
Watson et al 2000	EURO	Trial a benchmark tool to evaluate partnerships	Verona Benchmark is a tool being used across 15 sites across Europe which aims to improve the quality of partnerships. Community Planning is not new, other versions have been developed in Norway and Hungary.	The assumption is that partnerships work and community participation can enhance the health impact. Developed a tool to improve process of partnerships.	The benchmark reviews the process outcomes for partnerships. It does not investigate the cost or outcomes.	Test site selection opportunistic / logical. Talks about evidence but does not specifically reference any to support the claims.
Weerch-Maldonado et al 2003	US	To measure effectiveness of CHP	The authors propose that successful have multiple levels being community, network, organisation/ participants	Applied the Provan and Milward (2001) framework of community-based network effectiveness. Participant self-assessment survey data from over 400 cross 25 CHP with a 55% response rate.	Results suggest three levels of network effectiveness being: community, network, and organization/participant. Respondents identified two different organisation/participant benefits: enabling and client services. Intangible resources or enabling benefits received the lowest ratings. Community benefit and network effectiveness received ratings that	Limitations to the research as tables were unavailable on all databases due to an error.

Author/s	Details	Objectives	Overview	Methodology	Key Findings	Implications
					fall between the enabling and client services. The majority of respondents find at least some evidence of network effectiveness across all three levels of network effectiveness and all four dimensions of accountability.	
Weiss *et al* 2002	US	Developed a new measure partnership synergy, to assesses the degree of partnership's collaborative	*"Building effective partnerships is time-consuming, resource intensive, and very difficult"* *"Due to a lack of valid indicators, it has also been hard to* *document the effectiveness of partnerships in accomplishing health and health system goals"*  	Regression analysis. Clear eligible criteria. Of the 71 partnerships that were determined to be eligible, 66 partnerships in 28 states agreed to participate in the study. Questionnaires and Semi-structured qualitative interviews with 22 participants.	Examine the relationship between partnership synergy and six dimensions of partnership functioning: 1. leadership, 2. administration and management, 3. partnership efficiency, 4. nonfinancial resources, 5. partner involvement challenges, and 6. community-related challenges. Not all dimensions of functioning were equally important for synergy. Partnership synergy: closely associated with the effectiveness of partnership leadership and with partnership efficiency. (optimizes the use of its partners' time, financial resources, and in-kind resources) Last was synergy = Challenges	
Zakocs, & Edwards, 2006		aim to identify coalition building factors related to effectiveness	Nonetheless, two general indicators may be used to assess coalition effectiveness: internal coalition functioning and external community changes.	Published articles from 1980 to 2004 literature Review, yielded 26 studies	The 26 studies identified 55 coalition-building factors that were associated with indicators of coalition effectiveness. Six coalition-building factors were found to be associated with indicators of effectiveness in five or more studies: formalisation of rules/procedures, leadership style, member participation, membership diversity, agency collaboration, and group cohesion.	