# Evaluation Framework

## Overview

CESPHN is committed to rigorous, systematic and strategic evaluation to foster evidence-based decision making and a culture of continuous improvement. The importance of evaluation and using evidence from evaluations to guide our work is anchored in CESPHN's Strategic Plan 2019-2021. Evaluation is also a key component of the PHN Commissioning Cycle.

CESPHN's Evaluation Framework (the Framework) is designed to ensure that evaluation is high quality, ethical and focused on improving outcomes for the community. The Framework outlines the guiding principles for undertaking program evaluations and provides a structure for ensuring a consistent approach to evaluation and the selection of indicators to assess intended outcomes.

## Scope

For the purposes of this Framework, a **program** is defined as the related set of activities that have a common outcome for a client or client group. The term program is often used interchangeably with project or service.

**Evaluation** is the systematic collection and analysis of information to make judgements, usually about the effectiveness, efficiency and/ or appropriateness of a program. It is different to **monitoring**, which is frequently based on outputs not outcomes and involves the regular and continuous review of activities against planned targets.

This Framework excludes the evaluation of bids and responses to tender during the procurement phase of commissioning, which is covered under CESPHN's Procurement and Contract Manual.

## Guiding principles

CESPHN is committed to the following principles that underpin best practice program evaluation:

### Planning

1. Plan the evaluation at the design of programs to ensure clearly defined and measurable outcomes that can be evaluated.
2. Appropriately resource and time the evaluation during the program design. This includes allocating a budget (where applicable) and ensuring evaluation findings will be available when needed to support decision making.
3. Develop evaluation plans that include program logics and a data collection plan, to ensure consistency and to maximise the benefits of an evaluation.

### Scope

4. Scale the evaluation proportionate to the size, significance and risk of the program.
5. Evaluations should be outcomes focussed where possible.
6. Evaluation is not a replacement for the regular monitoring and performance review of contract agreements.

### Governance

7. Ensure there is the right mix of expertise and independence from the program when conducting the evaluation.
8. Identify and actively involve stakeholders in the evaluation planning process to ensure that definitions of outcomes, activities and outputs are determined in a collaborative way.

9. Conduct the evaluation in an ethical manner with proper oversight, ensuring adherence to relevant legislation and that participants are afforded with appropriate protections and respect.
10. Proactively communicate findings and recommendations to decision makers, stakeholders and the community.[1]

# Planning and execution

## Type of evaluation

An evaluability assessment should be conducted to determine whether an evaluation is justified, feasible and likely to provide useful information. This is particularly important if the program commenced without an evaluation plan (see below).

An evaluability assessment considers:

- Theory of change – Are the outcomes clearly identified and the proposed steps towards achieving these clearly defined? Do stakeholders hold the same views about the project objectives and how they will be achieved? Are there valid output and outcome indictors?
- Information availability – Do baseline measures exist? Is critical data available?
- Institutional context – Is the timing right? Are resources available to do the evaluation?[2]

The type of evaluation depends on the key questions that need to be answered and the stage of program development and implementation. A program evaluation may use one or more of the types of evaluation listed in Table 1.

**Table 1: Evaluation types**

| Type | Program logic | Key questions |
|---|---|---|
| Process | Inputs, activities and outputs | Have activities been implemented as planned?<br>What aspects of a program are working well and what aspects could be improved? |
| Impact and Outcome | Outcomes | Is the program meeting its stated objectives?<br>What difference did the program make in the short, medium to long-term? |
| Economic | Inputs and outcomes | Does the program provide value for money?<br>Did the benefits justify the costs? |

## Scaling an evaluation

Table 2 provides guidance on the scaling of evaluations commensurate with program characteristics. If program characteristics cross different scales then the highest scale would apply – for example, a low risk program with significant budget (> $500K p.a.) would require a Scale 3 type evaluation. For Scale 3 evaluations where an evaluation budget is to be quarantined, the recommended amount is 10 per cent of the total program budget.

[1] Adapted from the NSW Government Program Evaluation Guidelines, January 2017.
[2] Davies, R., 2013. Planning Evaluability Assessments: A Synthesis of the Literature with Recommendations. Report of a Study Commissioned by the Department for International Development.

**Table 2: Program characteristics and scale of evaluation**

| Scale | Program characteristics | Scale of evaluation |
|---|---|---|
| 1 | • Small budget (< $50k p.a.)<br>• Low risk<br>• Simple design<br>• Similar to previous evaluated programs that have been found to be successful | Evaluate at General Manager discretion. This could be a less formal evaluation that is conducted internally with few resources. At a minimum, the following information should be routinely collected:<br>• Program aim, inputs and activities outlined in a program logic<br>• Risks<br>• Performance measures (e.g. KPIs) |
| 2 | • Moderate budget ($50k-$500k p.a.)<br>• Low to moderate risk<br>• Not recently reviewed | General Manager to decide:<br>• To evaluate internally or contract out<br>• Evaluation budget (if applicable)<br>• Need for a Steering Committee and its composition<br>• Dissemination of findings |
| 3 | • Significant budget (> $500K p.a.)<br>• Moderate to high risk<br>• Complicated design<br>• Innovative, or a pilot, trial or proof of concept | Evaluation mandatory with:<br>• Quarantined evaluation budget<br>• Independent evaluation by external evaluator<br>• Steering Committee<br>• Dissemination of findings |

## Program logic

Program logics provide a clear line of sight between inputs, activities, outputs, and desired outcomes to help us understand what we want to achieve and how we think we will achieve it (i.e. the theory of change). It also helps in the selection of indicators to monitor progress and evaluate the success or otherwise of the program.

All programs should have a program logic that links to the overarching CESPHN logic model in Table 3. This will ensure that all programs are working towards the same strategic goals.

## Evaluation plans

To maximise the benefits of an evaluation, it should be well planned during the program design phase. Managers are responsible for developing evaluation plans that outline:

- Purpose of the evaluation
- Key questions the evaluation will seek to answer
- Budget and timeline
- Who will conduct the evaluation
- Ethical considerations
- Plans to disseminate findings.

The Planning and Performance Team will then review the program logic and evaluation plan to develop a data collection plan that lists indicators and data sources for each evaluation question. Examples of evaluation questions and indicators for short, medium and long-term outcomes can be found in Tables 4-6.

# Ethical considerations

Evaluations are to adhere to relevant principles and legislation, have appropriate oversight and ensure all participants are afforded appropriate protections and respect. Staff conducting evaluations need to consider a range of issues including identification of risks and burdens to participants, informed consent, privacy, and whether ethical review is required.

## Identification of risks and burdens to participants

All evaluation processes should carefully consider whether they pose any risk for participants beyond their routine environment. Identification of risks and burdens should consider physical, psychological and spiritual risk; as well as potential for social harm or distress (e.g. stigmatisation or discrimination).

## Consent

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

## Privacy and data security

Safeguarding the privacy and data of participants and/or organisations should be a key consideration when collecting information. Appropriate protocols must be planned prior to the execution of an evaluation regarding:

- Data confidentiality (e.g. is the information confidential?)
- Data accessibility (e.g. who can/should be able to access the data?)
- Data management (e.g. how will data be collected, stored, used, destroyed)?
- Legislation (e.g. are their pertinent legislature that need to be upheld?)

## Ethics committee review

All evaluations need appropriate oversight. This includes ethical review by a Human Research Ethics Committee (HREC) if one or more of the following triggers apply:

- If the purpose of the evaluation is beyond quality improvement.
- If you wish to publish the evaluation findings or present them at a conference.
- If the activity potentially infringes the privacy or professional reputation of participants, providers or organisations.
- Secondary use of data (that is, using data or analysis from QI or evaluation activities for another purpose).
- Gathering information about the participant beyond that which is collected routinely.
- Testing of non-standard (innovative) protocols or equipment.
- Comparison of cohorts.
- Randomisation or the use of control groups or placebos.
- Targeted analysis of data involving minority/vulnerable groups whose data is to be separated out of that data collected or analysed as part of the main evaluation activity.[3]

There are over 200 HRECs across Australia. The National Health and Medical Research Council (NHMRC) includes a list of NHMRC registered HRECs on its website. Ethics approval will need to be sought from the Aboriginal Health and Medical Research Council (AHMRC) if you are working with the Aboriginal community. Approval from the NSW Health Ethics Committee will need to be sought if

[3] Adapted from the National Health and Medical Research Council's *Ethical Considerations in Quality Assurance and Evaluation Activities*.

patients or staff from Local Health Districts are involved in the study. Obtaining ethics approval may take several months and therefore must be factored in during the planning stage.

**Table 3: CESPHN's overarching program logic**

| | | | | | | |
|---|---|---|---|---|---|---|
| **Aim** | Increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improve coordination of care to ensure patients receive the right care in the right place at the right time | | | | | |
| **Context** | PHNs improve outcomes by targeting unmet local needs with tailored services and improving access, supporting GPs and local health care providers to improve quality and coordination of care, and leading integration of primary health with the broader health system | | | | | |
| **Inputs** | **Participants** | **Activities** | **Outputs** | **Outcomes** | | |
| | | | | **Short-term** | **Medium-term** | **Long-term** |
| Funding<br>Workforce<br>Infrastructure<br>Information Technology<br>Data<br>Directed at priority areas:<br>• Mental Health<br>• Aboriginal and Torres Strait Islander Health<br>• Population Health<br>• Workforce<br>• Digital Health<br>• Aged Care<br>• Alcohol and Other Drugs | Residents of central and eastern Sydney<br>GPs and allied health professionals<br>Health care administrators<br>Peak bodies<br>Government (local, state and Commonwealth)<br>Researchers | Workforce development<br>Inform and educate health consumers<br>Develop and design programs, services, models of care<br>Commission programs and services<br>Practice support<br>Engage and consult with key stakeholders<br>Facilitate partnerships<br>Collate and analyse quantitative and qualitative data | Education and training of consumers and providers<br>Health resources (e.g. Health Pathways)<br>Uptake of technology (e.g. digital health)<br>Intra-sectoral and inter-sectoral partnerships<br>Commissioned services<br>Accreditation and quality improvement support<br>Research promotion and support<br>Needs assessments of community | Improved awareness, knowledge and skills<br>Improved coordination of care<br>Improved access to care<br>Improved quality of care<br>Improved appropriateness of care | Improved population health<br>Improved patient experience<br>Improved clinician experience<br>Value for money | Improved health and wellbeing |
| **Assumptions** | Established 1 July 2015 with ongoing funding | | | | | |

**Table 4: Short term outcome indicators**

| Outcome | Evaluation questions | Indicators (examples) |
|---|---|---|
| Improved awareness, knowledge and skills | • Do consumers understand information about health and health care, and how they apply that information to their lives?<br>• Do consumers/ health care providers have improved awareness, knowledge, and/or skills for behaviour change? | • Number of programs/ services that address health literacy<br>• Changes in pre and post assessment of awareness, knowledge and/or skills |
| Improved coordination of care | • How well is this service integrated with other services? | • Rate of GP team care arrangements / case conferences<br>• Rate of uploaded discharge summaries/ e-referrals<br>• Rate of regional population receiving clinical care coordination services for people with severe and complex mental illness<br>• Number of partnerships established |
| Improved access to care | • Are consumers who require services able to access them?<br>• Can consumers access services in a way that suits them?<br>• Do services account for the special needs of priority populations in the community and adjust aspects of service delivery to suit these needs? | • Rate of targeted population receiving services<br>• Wait times for services<br>• Rate of population receiving specific health assessments<br>• Rate of MBS services provided by primary care providers in residential aged care facilities<br>• Rate of children fully immunised at 5 years<br>• Cancer screening rates for cervical, bowel and breast cancer<br>• Rate of general practices receiving payment for after hours services<br>• Rate of GP style emergency department presentations<br>• Number of programs/services that target priority populations (e.g. Aboriginal and/or Torres Strait Islander peoples; culturally and linguistically diverse communities; people living with a disability; people experiencing homelessness; people experiencing socioeconomic disadvantage) |
| Improved quality of care | • Are services delivered safely?<br>• Is the service accredited?<br>• Is the service participating in continuous quality improvement?<br>• Did the consumer receive care when they needed it? | • Rate of clinical incidents<br>• Rate of general practice/ service accreditation<br>• Rate of general practices/ services participating in quality improvement<br>• Rate of potentially preventable hospitalisations<br>• Percentage of diabetic patients who have a GP annual cycle of care |

| | | |
|---|---|---|
| Improved appropriateness of care | • Consider clinical and cultural appropriateness.<br>• How appropriate (clinically and/ or culturally) is the design and execution of the service for the consumers it is for? | • Proportion of people referred to PHN commissioned services due to a recent suicide attempt or because they were at risk of suicide followed up within 7 days of referral<br>• Proportion of the service workforce who have completed culturally and linguistically diverse training<br>• Proportion of the service workforce who have completed Aboriginal and Torres Strait Islander cultural training<br>• Proportion services delivered to Aboriginal and Torres Strait Islander peoples that were culturally appropriate<br>• Employment of CALD staff<br>• Employment of Aboriginal and/or Torres Strait Islander staff |

**Table 5: Medium term outcome indicators**

| Outcome | Indicators (examples) |
|---|---|
| Improved population health | • Infant/ child mortality rates<br>• Self-reported health status<br>• Health related quality of life<br>• Potentially avoidable deaths<br>• Suicide rate<br>• Psychological distress<br>• Prevalence of chronic diseases<br>• Health behaviours (alcohol and drug use, smoking, physical activity, nutrition)<br>• Clinical outcomes (e.g. HbA1c, BMI, blood pressure) |
| Improved patient experience | • Consumer satisfaction rate<br>• Consumer experience rate |
| Improved clinician experience | • An active and engaged workforce:<br>o Staff satisfaction rate, pulse checks<br>o Training records<br>o Turnover, absenteeism rates |
| Value for money | • Per capita cost of health care |

**Table 6: Long term outcome indicators**

| Indicators | Indicators (examples) |
|---|---|
| Improved health and wellbeing | • Life expectancy<br>• Disability-free life expectancy<br>• Life satisfaction |