



COMMUNITY HEALTH PLAN 2003/04

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1. INTRODUCTION

This is the third Community Health Plan of the Northern Mallee Primary Care Partnership. This plan builds on these two earlier plans and continues the work begun since the inception of NMPCP in July 1999.

This Community Health Plan is produced to meet the requirements of the DHS as set out in their document “Template for 2003/04 Community Health Plan”.

In that document, DHS describes the purpose of the Community Health Plan as follows:

“Community Health Plans identify the priority health and well being needs of their communities and describe how the partners are working together with meaningful input from consumers and carers to:

- Improve health and well-being in their communities.
- Improve people’s experience of primary care services.
- Strengthen health promotion and service coordination
- Reduce preventable hospital admissions.”

BACKGROUND INFORMATION

The previous Community Health Plans, Health Promotion Plans and significant Demographic data covering the Northern Mallee can be found on the NMPCP website: www.northernmalleepcp.org.

Information about services available in the Northern Mallee can be found at www.connectingcare.com.

2. THE CONTEXT

2.1 PROGRESS TOWARDS MEETING STRATEGIC OBJECTIVES FOR 2002/03

The Strategic Objectives that NMPCP set for 2002/03 and the experience gained in working towards their achievement give some context to the development of the updated strategic objectives for 2003/04:

In 2002/03 eleven major Strategic Objectives were set out in our Action Plan under 26 “sub objectives” and 77 specific action items. This was a very ambitious undertaking given the “contraction” of PCP funding and the consequent likely loss of PCP support staff to assist member agencies take the action identified.

A detailed report on progress in relation to attainment of 2002/03 Objectives is set out in the June 2003 CHPIA report.

This section is a summary of this report with brief comments about the implications for on going objective setting and action in 2003/04.

Introduction of DHS Tool Templates (Initial Contact and Initial Needs) and movement towards a Common Service System

NMPCP set itself the ambitious goal of moving **all** member agencies to a common service system based on the mandated forms by mid 2003. Overall, NMPCP is nowhere near achieving this objective. However, achievements have included:

- high visibility of the Tools and the concept of a common service system,
- locally developed processes, practices and protocols,
- delivery of training in use of tools,
- development of significant user information,
- development of a referral feedback form and procedures,
- a groundswell of interest in the concept.

At a recent workshop on NMPCP vision for the future, the concept of the “common service system” was well supported. It is therefore appropriate to carry this Objective forward into 2003/04 but with a more realistic timeline and a focus on mandated agencies and practical support.

SAO Project - Improving the Quality of Initial Contact

NMPCP’s demonstration project commenced early in the year but outcomes have been patchy, reflecting inadequate design and implementation strategies and overly fuzzy ambitious goals. Whilst the project has kept the service system focused on issue of Initial Contact and needs for

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better initial needs identification, it has in itself only delivered modest improvement in consumer service.

While PCP remains committed to quality improvement at the initial contact phase, the “one model” approach no longer seems tenable as agencies have divergent “front end” systems to deal with their specific work demand. Future effort is best put into general upskilling reception and intake staff (including training in best use of the connectingcare.com service directory) and in providing in depth training for general intake workers seeking to improve/optimize their skills in initial contact and initial needs identification.

ENCRYPTED REFERRAL

The encrypted referral ‘project’ has been ‘completed’ by our contractor, but again real gains have been limited. This is clearly not a system change that can be achieved overnight! There are enormous problems across all dimensions in moving the Northern Mallee system from paper to electronic referral

While adoption of Encryption Keys and use for referral has been very slow, there does appear to be increasingly stronger interest by member agencies, in encryption and encrypted referral and it would seem appropriate to continue to prioritise its introduction during 2003/04 – preferably around small groups of agencies who traditionally have natural referral pathways (and continuing to use the HeSa system). The need to resource all the above three action areas with hands-on, IT savvy support staff is critical.

SERVICE INFORMATION

Efforts to enhance the Service Directory and highlight its importance in our service system have been successful. Many gains have been made in opening up service information to both provider and consumer alike. The need is to continue our current directions in 2003/04 and perhaps expand the ways in which we make information available. A “one stop shop” (front) or a Phone Information service would complement existing action, but needs to be carefully evaluated in relation to other existing services (i.e. Carelink) and funding issues.

SERVICE COORDINATION FOCUSSING ON AGED CARE FIELD AND “AVOIDABLE” HOSPITAL ADMISSION

There has been little real tangible gain in this area of work during 2002/03. There is still much work to be done, but it involves commitment for involvement by all sectors – primary care, General Practice, Acute and Residential. PCP needs to get back to basics before we can move forward. The importance of service mapping, quantification of service shortfall and clear specification of perceived problem issues is highlighted. This will guide our work in 2003/04.

GP ENGAGEMENT IN CARE PLANNING

This is an area of our activity which requires significant rethinking and planning. It has been universally experienced by PCPs statewide as a difficult area in which to achieve useful outcomes. It has been suggested that we need to employ staff to support action to move any workload along. Failing this we need to consider promoting primary care services to GPs through “at Clinic” forums or visits. Incremental successes such as ensuring feedback to GP

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referral may also be appropriate. Relationships with the local Division of General Practice are excellent and provide a good springboard for action.

HEALTH PROMOTION : MENTAL HEALTH

This strategy involved many agencies in a mix of information based and resilience building activity. It should continue in 2003/04 but with more focus.

HEALTH PROMOTION : CARDIOVASCULAR

The H.P. Working Party has continued to be active in developing a workable Health Promotion Agenda highlighting Health Promotion issues. Feedback from Agency members has been positive. In 2003/04, it is considered that the available funding must support hands on support for specific funding programs AND that **infrastructure** development must be prioritised. The need for the development of an area Health Promotion plan remains on the table for the third year.

Work on the specific Cardiovascular program emphasising mobility/activity through walking was slow although Ouyen services have moved decisively. In 2003/04 it is planned that this activity be continued as it is highly appropriate to Health needs and issues identified and good momentum for a regional strategy is building.

RECRUITMENT OF HEALTH AND ALLIED HEALTH STAFF

NMPCP member agencies continue to work on this very significant issue. A Recruitment & Retention Strategy plan was developed in 2002/03 and, NMPCP have endorsed further work. It is appropriate to keep this area moving, given the significant feedback about agency recruitment difficulties. Our efforts are strongly supported by a broad coalition of interests including the Area Consultative council and LaTrobe University.

INTERAGENCY COMMUNICATION

Considerable resources have been invested in interagency communication via regular information newsletters and the continued development of the NMPCP website. They have been well received. The issue remains how to encourage their "interactive" use by Agency Staff. It should remain a priority for 2003/04.

PLANNING

Some work has taken place at defining an integrated planning model and some useful initial discussions have been held with MRCC staff about integrating planning processes. It is a matter of high priority that we make decisions this year about the relationship of the myriad of local agency and sector planning processes so that cross agency planning can have credibility.

OTHER ACTIVITY AND INVOLVEMENT

NMPCP also undertook a range of other activity during 2003/04 related to individual client groups or sectors. Most of this can be generally regarded as broad Service Coordination activity

but it did include significant attention and appropriate action to improve our Governance and decision making structures.

- **Effective follow up of Suicidal Clients Presenting in Hospital Emergency Departments**

NMPCP has continued to support this Commonwealth funded Service Coordination program, jointly being trialed in the five PCPs of the Loddon Mallee Region. It is contractually bound to continue during 2003/04.

- **Integrated Disease Management (IDM)**

PCP has continued to support an Integrated Disease Management project in Diabetes Management through funding of Sunraysia Community Health Service for Encrypted Computer Technology to provide an integratable data base of consumers who have Diabetes.

NMPCP supports IDM activity but because of funding issues will not actively pursue IDM during 2003/04.

- **Drought and Rural Downturn**

NMPCP called together the Agencies who have been contracted to provide assistance to Farmers and other persons affected by Drought and Rural Downturn. These coordinating meetings serve for both Information swapping and Needs and Gaps analysis opportunity.

A pamphlet aimed at rural community members about assistance available has been compiled, printed and distributed to relevant points in the rural communities. It supplements other information given to Agency staff and available through the NMPCP web site.

NMPCP believes that this is an important activity linking a range of our other priority actions. It is proposed to continue supporting a coordinated response.

- **Youth Strategy Plan**

NMPCP worked closely with Agencies in the Youth sector to develop a Strategy Plan. NMPCPs ongoing interest is to integrate the Youth Plan into one master planning process.

- **Youth Police Early Intervention Referral Scheme**

At the instigation of the Local police, NMPCP called a meeting of agencies with a view to developing a comprehensive referral scheme from police "on the beat" to local agencies to ensure early intervention with Youth at initial points of problematic behaviour. This has been done and the scheme is operational. No further action is contemplated.

- **Aged Care Planning**

NMPCP worked with the Network agencies to increase the planning focus and role of the Aged Care Network. It is intended that this focus of PCPs activity continue in 2003/04 not only with the Aged Care Network but with all sector networks.

- **Regional Suicide Action Plan**

NMPCP called a meeting of local agencies to hear about the DHS Loddon Mallee Suicide Plan "Connections". The meeting requested that the HP Working Party monitor and help implement the Action Strategies as part of their Mental Health Health Promotion activities.

- **Governance**

During the year, NMPCP changed its Governance Structure to add 3 new members to its existing 7 member Executive. This new Executive of 10 members (3 elected annually), meets monthly and is a better balanced decision making structure. NMPCP abolished the category of Affiliate members to create one category of membership only. The full membership now meets, as the Advisory Forum, on a quarterly basis.

Overall, NMPCP now believes it has a more effective and inclusive governance structure though it remains open to further changes if they improve decision making and collaborative practice. NMPCP will continue to monitor and strengthen our Governance Structure.

2.2 SUMMARY OF 2002/03 PROGRESS

NMPCP has undertaken a range of activity across the major objectives it specified in its 2002/03 CHP.

The strengths of our activity have been in:

- Improvement in our Governance Structure and retaining the engagement of agency staff and agencies in supporting PCP collaborative partnership activity.
- Optimisation of our Electronic Service Directory.
- Development of Interagency Communication processes and communication from PCP Secretariat to Agencies.
- Publicising and training in the area of Mandated Tool Templates and Encrypted referral.
- Health Promotion infrastructure development and staff connection.
- Continuing attempts to promote the integration, coordination and planning of service delivery.
- Movement towards Integrated Planning structures and towards highlighting the importance of cross agency planning.

The weaknesses of our activity have been in:

- Lack of problem definition in respect of needs to improve Service Coordination and service delivery between sectors e.g. avoidable hospital admission.
- Slow implementation of Encrypted Referral.
- Intangible outcomes from our "SAO" pilot project.

The opportunities for the future are seen to be:

- Capitalising on the latent support of Agency staff for uptake of PCP objectives.
- Building on the strengths of our **Service Information** infrastructure particularly in improving access for consumers (and agency staff).
- Building on a mutual desire to have common planning system integrating statutory plans (Municipal P.H. Plan) and other planning processes (CHP, Mental Health Plan etc).
- Opportunities presented by the Regional ICT Governance structure, strategy plan and DHS funding rollout for ICT connectivity.
- Our experience of three years “collaborative” activity with broad consensus and a vision of where we could move to and general agreement on practical ways to get there.

The threats to success of our PCP are:

- Lack of commitment from Agencies for broader PCP agendas in the face of real funding constraints impacting on specific agency functioning.
- Inadequate funding of PCPs which restricts the ability to provide support staff to drive collaborative agendas.
- Variability in DHS efforts to “encourage” agencies to participate in the collaborative agenda and associated processes (particularly the absence of practical inducements).
- Continuing (funder induced) fragmentation of service sector – particularly aged care and mental and emotional health, (making coordination and collaboration difficult).
- Lack of action to integrate and/or harmonise local planning processes.
- Being spread over too many agendas without achieving tangible outcomes in any.

3 DETERMINING KEY HEALTH ISSUES

3.1 PROCESS FOR DEVELOPMENT OF 2003/04 PLAN

This plan has been developed after summarising input invited from member agencies about needs, issues and service gaps. The written summary of the input was the focus of a Consultation meeting with all member agencies in mid June. At this meeting, representatives from 17 of our 21 member agencies gave feedback which was included in a subsequent draft sent out for comment.

This document represents the final views of member agencies on the appropriate directions of our Community Health Plan 2003/04 and the action that needs to be taken. It should be noted that unlike the 2001/02 and 2002/03 Community Health Plans, this CHP has had no Community Consumer or Carer input.

3.2 SUMMARY OF KEY HEALTH ISSUES FOR THE NORTHERN MALLEE 2003/04

The **key** (broad) priority health issues for **2003/04** in the Northern Mallee which have been identified by local agency staff and confirmed in subsequent Member Agency consultations are similar to those identified in 2002/03 viz:

- Cardiovascular Disease – increasing trend to poor fitness level and obesity, causally linked to Diabetes and other related “lifestyle” contributed illness;
- Emotional and Mental Health – particularly depression;
- Independent Living Support – particularly among Older People;
- Inadequate housing, homelessness, unemployment and issues causally related to low income issues;
- Family breakdown, domestic violence and related family “pathology”;
- Shortfalls in Community Transport services combined with limited public transport infrastructure;
- Shortfalls in Medical, General Practice and Allied Health Staff;
- Dental Health in lower income groups.

Other issues which have been identified as problematic (but not necessarily of high priority):

- Lack of step down facilities for the elderly being discharge from an acute setting;
- Supported Residential services in the community for people with serious mental illness as a further support option;
- Increase in number of teenage pregnancies contributing to the highest percentage of mothers under 20 in the state;
- Inadequate levels of Nursing home beds and agencies willing to provide them.

3.3 SERVICE GAPS AND SERVICE NEEDS RELATED TO KEY HEALTH ISSUES 2003/04

These service gaps either implicitly or explicitly related to the key health issues identified are similar to those identified in 2002/03 and include:

1. **Services (and service time) to support people's independence in the Home** i.e. Early intervention to prevent problems particularly Risk Assessment and Safety reviews, Medication Reviews, carer respite, home help support.
2. **Socialisation activity** including social groups for older people to improve opportunities for social contact, to improve health and well being and lessen the incidence of depression in the aged.
3. **Family, Relationship and personal Counselling**, parenting support and interpersonal skills development services.
4. **Support services for young people** including drop in and outreach services and programs to help management of depression, increase connectedness and improve resilience. Noting, however, the increase of service in Robinvale and Ouyen.
5. Increased provision of a range of **free or significantly subsidised Transport services** and options to assist consumers get to and from primary care services and medical and social support.
6. Public Dental Services.
7. More **variety in the forms of accurate information services** about the range of primary care services and programs, and more publicity about them, (including face to face services).
8. Capacity of Mainstream agencies to support and complement existing **Ethno-specific service providers** to increase support to specific groups in need and ensure access to mainstream services.
9. Increased **availability of secure public housing** to meet current high needs.
10. Staffed residential **support services** for people with a psychiatric disability to help them live independently.
11. Availability of a **bulk billing General Practice clinic** for the significant proportion of people in the community who cannot afford to access general practitioners.
12. **GP Home visits to Aged Care** facilities.
13. Availability of an after hours GP service to help reduce the inappropriate use and demand on A & E.
14. The availability of **specialist 24 hour residential care** for people with a Mental Illness who do not require hospital care but do require high levels of support.

15. A **step-down facility** for elderly being discharged from an acute setting.
16. **General Practitioners and Allied Health staff** shortage are seen to be a continuing issue for many organisations – but the issue falls across most professional areas with the following specifically identified:
 - Genetic counselling
 - Speech therapy services in Early Intervention Setting
 - Physiotherapist : specialising in Pediatrics
 - Pediatricians
 - Occupational Therapy in Ouyen
 - Audiologist

3.4 KEY HEALTH ISSUES : DISCUSSION

Detailed comments in relation to each area itemised in Section 3.2 above are as follows:

1. Cardiovascular Disease

Cardiovascular Disease and other predominantly lifestyle caused illnesses (particularly type 2 Diabetes) which are causally linked to lack of activity, lack of fitness, smoking, obesity and poor diet (particularly in those over 45) is a major problem in the Northern Mallee.

Data

Data on incidence Cardiovascular disease was presented in our first Community Health Plan and will not be repeated here. The issue however is the lifestyle behaviors that sustain these illnesses.

There is also seen to be a significant increase in the incidence of Type 2 Diabetes particularly in the Koori population.

Implications for Action

Lifestyle related illnesses and diseases lend themselves to Health Promotion Disease Management and related Health information strategies.

Over the past two years, the NMPCP has focused its general Health Promotion funding onto strategies to reduce Cardiovascular Disease. Last year and this current year, the focus has been on improving the fitness levels of the population through the promotion of walking and other activity.

Physical “Fitness” and mobility (and associated weight loss) are clearly identified as having significant impact on both cardiovascular disease and Type 2 Diabetes. Consequently action in relation to this Health issue will continue to be Health Promotion focused. It is also considered appropriate to continue to actively support Disease Management initiatives – particularly Type 2 Diabetes management.

In 2002/03, NMPCP invested over \$25,000 of its own funds in a local Diabetes Management project. NMPCP will continue to monitor this project's development and link it with other related activity (Information strategy, health promotion etc).

2. Emotional and Mental Health

Emotional and Mental Health problems and issues are caused by a broad range of factors and impact on diverse population groups. Of particular significance are:

- Incidences of poor self esteem, anxiety and depression among younger people. Among this group are significant numbers of young women with eating disorders and co-morbidities such as depression.
- Stress, anxiety and depression and a worrying incidence of suicide in rural communities caused by drought and rural downturn impacting across all population groups but particularly male farmers.
- Depression in older people due to loss and grief issues and isolation.
- Post natal depression which is seen as an increasing problem particularly in rural areas. This is magnified by an increase in the number of teenage pregnancies and a high proportion of young mothers in the general population.
- Stress and depression related to family breakdown, unemployment and inadequate housing.

Data

There are many agencies in Northern Mallee having involvement in service provision for people with Emotional and Mental Health issues including:

- Primary Mental Health Early Intervention Service (community based);
- Mildura Base Hospital Mental Health Service;
- Centacare (counselling);
- Sunraysia Community Health Service (counselling);
- Sexual Assault and Domestic Violence Services;
- Mallee Division of General Practice through its MAHS program;
- Robinvale District Health Service through its Social work Section;
- Mallee Family Care Family Counselling and support
- School focused Youth Support Services

The Primary Mental Health Early Intervention Service forms an alliance with significant players above, as the Northern Mallee Mental Health Alliance, and produces a Mental Health Plan. Many services also attend bi-monthly Mental Health Network but its function is largely information exchange.

There appears to be an absence of recent service mapping and quantifiable service gap analysis. Such a lack of hard data makes reliance on less reliable qualitative agency data essential. There is a local consensus that there are shortfalls in publicly provided direct service activity – particularly high quality professional counselling services and particularly services targeting youth and adolescents, relationship and families. This is consistent with the views expressed by Statewide reports, that the availability of a suitably skilled workforce, is possibly the single most important issue facing mental health services in Victoria (Victorian Rural Services Strategy P21). There is also increasing concern about the mental health of people in remote and rural areas. Specifically, families affected by drought and rural downturn, isolated women generally and younger women suffering post natal depression.

One issue constantly mentioned is the issue of the lack of information about mental emotional illness **and** about the availability of local services who can assist (although these are limited in rural areas).

Implications for Action

The lack of overall planning, service mapping and gap analysis in the Mental Health Sector, is a cause for concern as such quantitative data forms the basis of action to rectify problems and provide needed services. The deficiencies in direct service provision can only be identified by a reliable quantitative analysis. Following such analysis, NMPCP needs to address recruitment, retention and upskilling agendas.

The task for NMPCP is to encourage such activity and bring important players together to plan to overcome deficiencies. The issue of lack of mental/emotional health information lends itself to Health Promotion activity – particularly in the provision of information which helps to normalise and destigmatise emotional health issues.

The increasing concerns about the mental and emotional health of people in Rural areas affected by rural downturn points to a need to positively consider the continuation of NMPCPs current coordination support role between the various services providing assistance.

3. Independent Living Support: Older People

Increasingly being seen as a significant issue for an areas with a fast growing ageing population combined with an inadequate level of public funding to support adequate Independent Living and related supports.

Of particular significance are:

- The inadequacies in the provision of transport assistance to support people with Disabilities and the elderly in getting to medical appointment and social activity (which is compounded by a weak public transport infrastructure (routes and service frequency)).

- Inadequate home care support to optimise independent living in the community for the elderly and their carers, particularly among the frail aged and the remote and isolated aged population. Compounded by increasingly longer waiting lists for service.
- Inadequate service time for those with Dementia and associated conditions. This issue puts acute services under pressure when independent living breaks down. Because of lack of support, the older person is often forced into acute facilities. It is predicted that there will be a significant increase in the number of persons with Dementia by 2016 and that it will be the leading cause of female ill health (Victorian Rural Human Services Strategy).
- Inadequate opportunities for socialisation causing isolation, withdrawal and depression.
- Increasing number of early retirees on inadequate incomes and including those moving into the area with fewer social supports.
- Lack of High Care beds putting increasing pressure on community based support services who are not staffed to deal with these needs.
- Increasing pressure on carers.

Data

According to the Mildura Rural City Council the number of people on the waiting list to receive General Home Care is 65 with the number of total unmet need hours for the last month at 271 for consumers eligible for service and assessed as needing it.

There is a four week waiting period to receive Home Maintenance Service (this has been up to 6-7 weeks at some points). However, if the issue is an urgent one it is dealt with in 24 hours. Currently there is no waiting list in Personal Care. The implications for consumers health and well-being are far greater if a waiting list is implemented for Personal Care.

See the section on Transport for data relating to that need.

Implications for Action

As in the Emotional and Mental Health area, there is a significant amount of anecdotal information from service providers about unmet needs but there is insufficient hard data about the issues and problems in relation to service coordination. Hard data that does exist indicates significant waiting lists for a range of home care/help services.

There is also little quantifiable data about shortages of related Allied Health support, risk assessment and risk education services (e.g. falls prevention). The major implication for NMPCP is that it must pull together more specific information about the range of needs to assist elderly people live independently in the community.

Dementia is an issue that needs investigation in terms of local support services availability and capacity.

4. Inadequate Housing, Homelessness, unemployment and related Inadequate Incomes

While not “health” issues in the strict sense of the word, these situations have an enormous impact on the health of the community and on individuals experiencing them. There are increasing numbers of people with low socio-economic status in the Northern Mallee. Well known impacts are:

- Inability to afford bills, food and basic items including general practitioner and specialist medical assessment assistance (in an environment of increasingly larger Medicare gaps!)
- Family instability, family violence;
- Crime and school truancy;
- Depression, anxiety stress and other mental health problems;
- Substance abuse;
- Physical health problems as a result of much of the above.

The above impacts in turn lead to issues of safety in the community.

Data

The median weekly family income and median weekly household income are lower in Mildura than for the whole of Victoria. Currently, Mildura has both a high unemployment rate and a high demand for appropriate housing. This is in a context of a relatively low level of available affordable housing compared to the rest of Victoria. There is a marked increase in the number of people who are homeless or transient. This is possibly caused by drift into the area by those seeking the lower cost of living and lifestyle factors offered by Mildura (although there is debate about this).

Implications for Action

NMPCPs action boundaries are significantly stretched by application of the Social Model of Health to suggest appropriate modes of intervention related to these issues.

The major implication is the need to forge alliances with agencies and sectors dealing specifically with these issues and to ensure the provision of information about relevant needed Health and Primary care services is available to them. PCP must also be aware of the Mental and Emotional Health service needs generated by poverty cycles. Continuation of current work to involve the LLENS sector in developing a broader Common Service System and in participating in using the Electronic Service Directory, together with enabling our Housing Service Agency members (Loddon Mallee Housing Services and Mallee Accommodation Support Program) to input productively into NMPCP Information gathering and decision making are the major action areas for PCP.

PCP can also play an information dissemination and “lobby support” role.

5. Family Breakdown, Domestic Violence

These issues were identified in the previous two years and remain problematic. Family Breakdown, domestic violence and related family pathology are partly caused by a constellation of environmental factors and interpersonal skill deficiencies (including parenting skills, communication and conflict resolution skills, relationship skills and problem solving skills) seen to be having a particular impact on children. PCP have had little impact on these problems have taken no coordinating or leading role in bringing agencies together to address issues.

Data

A number of agencies work in this area of need including Mallee Family Care, Centacare, Mallee Sexual Assault Unit and the Domestic Violence Service and the Sunraysia Community Health Service. There are also generic Social Workers and Psychologists in generalist agencies who deal with these issues. Specific problem incidence data is not readily available, although in 1999 Mallee Family Care sought agency input about the need for relationship counselling. During this year, the Domestic Violence service and the local Police jointly expressed concern at rising levels of Domestic violence.

Implications for Action

These issues of family and relationship breakdown have been well know for some years, but it has been difficult to attract funding to recruit workers to deal with them. Generally, there is a shortage of skilled, trained, competent personnel to run complex individual, family, relationship and group counselling services to meet the needs of the community. It is of significance that many direct care workers in public funded services contract the relatively small private sector to do the more complex personal and interpersonal work with difficult clients.

There appears a need not only to map and quantify the unmet needs and service gaps, but also to provide skills training and professional supervision to existing workers to improve confidence and skills and to give them on-going support – this is particularly true when many counselling professionals are recruited as 1st year graduates.

While the obtaining of hard data about needs and gaps is the first priority for PCP, the related issue of upskilling and professional development forms part of the broader recruitment and retention agenda.

Finally, some of the problem is information based and could be dealt with on a social marketing/health promotion basis aimed at destigmatising “victims” and letting them know of assistance available.

This would seem to be particularly difficult and on going issue that requires urgent multi agency attention and problem solving as a high priority. PCPs role may be to get agencies together to address these issues.

6. Ethnic and Indigenous Health Issues

Health issues among Ethnic and Indigenous groups are similar to those issues described above. Among Pacific Islander and Indigenous Australians, the incidence of Type 2 Diabetes and Cardiovascular disease is significantly higher than the general population.

Family breakdown, domestic violence, substance abuse, chronic levels of diabetes and high incidence of early mortality have been identified as significant issues for the Aboriginal population and certain sections of the Ethnic population.

Data

There is an increasing diverse ethnic population including Turkish and more recently Iraqi, Tongan and South East Asian. There is also a high need Koori population receiving the majority of its services from Aboriginal Co-operatives.

Implications for Action

Education of staff at mainstream agencies in culturally appropriate ways to provide service is seen to be important in facilitating the access of and use by Koori and ethnic people. There are seen to be significant emotional health issues for Koori women which need to be addressed through consultation between local co-operative staff and mainstream services.

Despite significant action items in its last plan requiring PCP to open up communication channels with Aboriginal organisations, no progress was made. Those action items from last year, particularly to open dialogue on a formal on-going basis, need to be carried forward.

NMPCP also needs to be particularly open to supporting Agencies who are taking (or want to take) steps to open services up to people of different cultural backgrounds.

7. Dental Health

Information from the local North West Dental group expresses concern about the high level of dental caries seen with the community in this region with a non-fluoridated water supply. In Mildura, this high rate of caries is exacerbated by extremely long waiting lists for those seeking non urgent public Dental Treatment.

In Mildura, the waiting list is now 3 years and the waiting list for Dentures, 16 months. This situation is partly caused by difficulty in recruitment of qualified Dental staff as Dental "Chairs" are available.

This situation is not unique to Mildura. External reports predict a shortfall of 20% in supply compared to demand – and having most impact in Rural Communities (Victorian Rural Human Services Strategy).

Fluoridation of the local water supply looms as a long term preventative measure which over time may contribute to a lessening demand for service but measures need to be taken in the shorter term.

Implications for Action

Efforts to improve recruitment of professionals to Mildura may induce Dental staff to the area to fill established vacant positions. Support for fluoridation of water as having a long term preventative impact on Dental Health is also indicated. In the short term, NMPCP should support SCHS in whatever way it can assist them reduce unacceptably high waiting lists.

Ultimately, this seems to be a professional undersupply issue that PCP can only address on macro levels – probably through its “recruitment and retention” activity.

8. Community Transport

Community Transport has been a high priority issue for this PCP for the past two years. Last year, DHS responded to the issue by funding a part time project officer to work locally to seek ways to deal with the issues.

With an increasingly ageing population, however, SunAssist, the Community Transport Service which depends heavily on volunteers continues to have trouble meeting demand and recent changes to the HACC funding allocation are seen to have particularly adverse impacts on the service.

The new HACC funding allocation means that there will be no growth dollars for Volunteer Coordination for the next three years. SunAssist receives most of its funding through Volunteer Coordination dollars as HACC does not officially fund transport. This means that they have no capacity to run **extra** vehicles in the fleet if they are able to source funding for them.

There is concern that without support to mobilise new vehicles over the next 3 year cycle, there will be (as a conservative estimate) 372 people on a waiting list for transport. SunAssist maintain that the impact on the service system, of that waiting, will be huge. Clients will have difficulty getting to medical appointments and consequently , the demand for hospital beds will be higher, and the demand for HACC services, like home care to do shopping, personal care and district nursing will increase as these people try to continue to live in the community. There will also be a higher demand for nursing home beds.

Implications for Action

The Community Transport provider, SunAssist needs a more equitable and relevant funding source than HACC Volunteer Coordination, which does not fit their circumstances. NMPCP must assist HACC to lobby for better funding arrangements as a matter of priority.

9. Youth Services

The major concerns in respect of youth services and youth needs relate to mental and emotional health issues such as anxiety and depression, eating disorders and substance abuse. Preventative strategies include resilience building and developing self esteem, communication and conflict resolution skills.

Responsive strategies involve increasing the number and skill levels of counselling and support staff in the public sector, particularly those dealing with more entrenched emotion/psychological issues.

Implications for Action

In 2002/03, NMPCP supported youth agencies in developing an Action Strategy Plan. In 2003/04, PCP should support agencies in updating this plan as the blueprint for action and development of service responses. On the preventative side, PCP's Mental and Emotional Health Promotion Strategy will target information giving about Emotional Health and about available Counselling and Mental Health Services.

Recruitment and Retention Strategies are also needed to encourage helping professionals into the area to fill established vacancies.

Finally, PCP should encourage all sectors to consider provision of services and facilities to encourage resilience and social connectedness including sporting and recreational facilities.

PCP can also support continuing action to provide bulk billing clinics for young people currently auspiced by the MDGP.

10. Recruitment and Retention

This is an issue not unique to the Northern Mallee and well identified by Government with increasing availability of resources to support action. The issues are complex and action for resolution needs to be taken on many levels.

Implications for Action

NMPCP must keep this issue identified and forge broad coalitions with other sectors. Most importantly will be work to identify actual needs and collaborative action, specific to Northern Mallee to attract workers to the region (at the expense of other geographic areas). In the longer term, PCP must also lobby appropriate levels of government to increase the size of the pool (including the provision of local professional training for mature age groups currently living in the area).

This issue is of particular importance and priority to NMPCP.

3.5 ISSUES AND NEEDS NOT IDENTIFIED THROUGH AGENCY CONSULTATIONS

The NMPCP is mindful that consideration of the following issues has been limited and generally does not feature in ongoing action in this current Community Health Plan.

1. Drug and Alcohol issues – Issues of substance abuse have not stood out during the Agency consultative phase though its impact is seen as significant.
2. Ethnic Service Development or issues related to Ethnic Service Delivery (other than in Robinvale).

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3. Aboriginal Health development and issues relating to Service delivery for indigenous Australians.
4. Disability issues including Service Access (though a Disability Network is active and the local council employ a Disability Access Officer).
5. Consumer Input into Health Service Development and on going service delivery.
6. Service Quality issues including accreditation, quality service standards and so on.
7. Health Issues for Women – though some are address under Mental Health.
8. Volunteer Issues – including demands made on voluntary committees of management and increasing complex public liability and related insurance issues.

The credibility of this Community Health Plan is accordingly diminished by these omissions but our broad strategy emphasises action this year to integrate the various planning processes. This should ensure that subsequent plans are indicative of needs of all major population groups and sectors.

The emphasis of our 2003/04 Plan is on **broad health issues** not specific population groups, although many specific groups are clearly identified in discussion of the broader issues.

3.6 SOME “ENVIRONMENTAL FACTORS INFLUENCING THE DEVELOPMENT OF THIS CHP

Community Health Plans do not evolve in a vacuum. There are significant external factors and imperatives that influence the choice of actions taken in relation to needs and issues identified. Some of the most significant of these are considered to be:

1. The current ICT Funding Roll out from the Victorian Government and the Regional ICT Strategy plan and Governance arrangements now put in place. Over 2.5 million dollars is now available for this region. This has a potential impact on a range of interests and strategies of this PCP including, encrypted referral, electronic diabetes database, interest in medical video conferencing, our electronic service directory, local call long distance telephony possibilities and so on.
2. The availability of two major Health Promotion funding “buckets” for specific H.P. campaigns – which influence the way we develop health promotion plans and afford opportunities to set in place more sustainable H.P. agendas.
3. The DHS requirement that selected agencies use the new IC/INI tool templates by January 2004. Such a requirement, coupled with the clear expectation that PCP facilitate such a process requires NMPCP to continue to support agencies introduce these templates.
4. The Legislative requirement that Mildura Rural City Council needs to develop a Municipal Public Health Plan (with some overlap with the CHP) and the increasing number of local, State and regional plans seemingly unconnected and unco-ordinated at local level.
5. Continued interest by DHS in Service Information Directories and sustainable update strategies combined with Federal initiatives in Service information e.g. Carelink, making it imperative for local communities to have a clear information strategy which coordinates and integrates the external imperatives.

6. Changes to funding allocations in key areas which can impact on local service delivery sustainability e.g. inadequate funding for Community Transport providers could have enormous impact on Northern Mallee.
7. Strong emphasis on Health Sector Reform impacting on the push to reduce demand for acute services. This in the context of the unique Northern Mallee situation of two multipurpose services and a privately provided public hospital.

There are many action plans, strategy plans and other reports setting particular directions for rural health and primary care services addressing particular population categories (e.g. Victorian Rural Human Services Strategy). There is also much action taking place to better plan and integrate strategies across regions e.g. Suicide Action Plan and more recent activity to develop a Regional Alcohol and Drug Strategy.

The challenge for NMPCP is to keep abreast of all such reports, action strategies determine how they impact on NMPCPs agendas and ensure that NMPCP agencies have a voice at the decision making and action tables and integrate and coordinate our responses.

4. OPERATIONAL PLAN 2003/04

4.1 DEVELOPMENT OF 2003/04 STRATEGIC OBJECTIVES

For 2003/04 NMPCP has set 4 major strategic objectives. These give rise to 20 sub-objectives and 38 specific action items.

The 4 major strategic objectives are to:

1. Build Collaborative Infrastructure
2. Take action to overcome service gaps
3. Develop a Coordinated Delivery System
4. Improve capacity of the Service system to deliver a **range** of service responses including Health Promotion.

Action to address most of the key Health Issues, (Section 3) are covered under these major objectives. Specification of these 4 objectives and rationale for choosing them is as follows:

OBJECTIVE 1 : BUILD COLLABORATIVE INFRASTRUCTURE

- **Continue With Collaborative Infrastructure Development To Support The Concept Of The Northern Mallee Service System**

Rationale

NMPCP believes that **system** building and **system** sustaining activities are the key to the long term future of our collaborative partnership. Activities that are key to **system** development are integrated planning, interagency communication, staff recruitment and retention, development of multi modal service information delivery systems, optimisation of Information and Communications Technology, development of and sharing of generic training opportunities etc.

NMPCP believes that within the context of action to improve this infrastructure (including improving our decision making apparatus), a more responsive and capable service system will emerge which will be more capable of meeting client needs.

OBJECTIVE 2 : TAKE ACTION TO OVERCOME SERVICE GAPS

- **Identify And Take Collaborative Action To Overcome Critical Service Gaps And Service Shortfalls**

Rationale

Once needs, gaps and shortfalls are reliably identified, NMPCP must work at ways of overcoming them. This will include better usage of resources, pooling of resources and developing well documented cases to justify more services, and lobbying for more resources. In the end, however, resources are finite and the service **system** also needs to be creative and innovative in its search for solutions to complement more conventional approaches – this may involve broader partnerships with other major sectors.

OBJECTIVE 3 : DEVELOP A COORDINATED DELIVERY SYSTEM

- **Improve Service Coordination to Optimise Current Resourcing Levels, Improve Consumer Experience of the Service System and Reduce Demand on the Acute Sector**

Rationale

Improvements in Service Coordination can improve the experience of the consumer with the service **system** and give a more seamless delivery of the right services at the right time. Service Coordination requirements are also strongly driving the PCP agenda and driving the setting of PCPs contracted deliverables by the funding body. Service Coordination improvement (whole important) is not however, seen as a panacea for all service delivery problems. Hence the importance of our infrastructure building and Action Objectives to complement it.

OBJECTIVE 4 : IMPROVE CAPACITY OF THE SERVICE SYSTEM TO DELIVER A RANGE OF SERVICE RESPONSES INCLUDING HEALTH PROMOTION

- **Support the Development of a Multi Modal Primary health System and improve:**
 - **the Visibility and Acceptability of Health Promotion Illness Prevention and Disease Management Activity, and**
 - **the Capacity of the Service System to Implement Quality Health Promotion Campaigns**

Rationale

NMPCP do see the importance of improving the capacity of the service system to deliver quality health promotion and illness prevention activity as an integrated part of responses to deal with Health issues generally.

Attention to staff and agency **capacity building** in Health Promotion is equally as important as actual delivery of specific “demonstration” Health Promotion Programs through DHS PCP funding. NMPCP continues to seek to encourage a reasonable balance between service activity which is responding to illness and disease and activity which is preventative. It also seeks to encourage activity which requires exclusive professional management and activity which encourages consumer and carer management.

Very clearly many of our identified key health issues set out in Section 3.4 above, do respond very well to health promotion initiatives.

4.2 2003/04 MAJOR AREAS OF ACTIVITY

Under each of the 4 major objectives, NMPCP have determined sub-objectives or major activity areas. These in turn are the subject of a detailed Action Plan.

OBJECTIVE 1 : BUILD COLLABORATIVE INFRASTRUCTURE

1.1 INTEGRATED PLANNING

Develop an integrated planning process for the Northern Mallee Health and Primary Care Sector in which all current sector plans (but particularly the Mildura Municipal Public Health Plan and the Community Health Plan) are related and link each to the other with agreed processes and protocols for the determination of needs and gaps and the development of a comprehensive overall action plan for the Northern Mallee Region.

1.2 IMPROVE CONSUMER PARTICIPATION

Develop strategies to best harness consumer input into identifying the Health needs of the Community and into feedback about, and development of, services.

1.3 INTERAGENCY COMMUNICATION

Continue to enhance interagency communication through continued development of established channels of communication such as:

- the NMPCP Website
- The NMPCP Newsletter
- the Sector Networks Provider groups and Reference groups.

1.4 ICT STRATEGY

Determine local ICT needs, develop local ICT priorities, become informed about the practicalities of and participate in the roll out of, the Regional ICT Strategy plan and develop an action plan for achievement of needs not encompassed by the Regional Strategy Plan.

1.5 RECRUITMENT AND RETENTION OF MEDICAL, ALLIED HEALTH AND PRIMARY CARE PROFESSIONAL STAFF

Continue work to take a Northern Mallee approach to defining needs and developing and then implementing a common and shared strategy to enhance staff recruitment and maximise retention of staff. Involve a broad coalition of interests.

1.6 GOVERNANCE AND SUSTAINABLE PARTNERSHIP DEVELOPMENT

Continue to develop our decision making and collaborative agency meeting structures so that all health and primary care agencies and services are encouraged to belong and are able to participate.

1.7 SERVICE INFORMATION

Continue to optimise the local electronic Service Directory, Connectingcare.com, to improve its accuracy, its breadth of content coverage and its utility as a referral tool for service providers and the wider community alike. Develop a variety of formats for imparting the service information collected and publicise their availability.

1.8 RESPOND TO OPPORTUNITIES, GAPS AND “THREATS”

Develop the Service Systems storage of key information and data to support rapid response to funding and/or other opportunities to deal with service gaps or shortfalls. Convene troubleshooting meetings to address service coordination issues or external threats.

OBJECTIVE 2 : TAKE ACTION TO OVERCOMESERVICE GAPS

2.1 COUNSELLING SERVICES

Map services and ascertain service gaps and unmet demand. Look broadly at ways to overcome service gaps and optimise capacity of existing staff in delivery of service. (Link with Recruitment and Retention Activity).

2.2 SERVICES SUPPORTING INDEPENDENT LIVING FOR OLDER PEOPLE

Identify the **specific** gaps and **specific** shortfalls and weaknesses in service delivery and take subsequent collaborative action to move towards meeting those needs.

2.3 YOUTH SUPPORT SERVICES

Assist agencies to implement the Youth Services Strategic Plan and to update the plan as necessary. Support efforts to coordinate existing services and obtain new ones to fill gaps.

Focus on preventative and/or early intervention as appropriate.

2.4 TRANSPORT

Identify needs, prioritise and plan to take action to ensure that essential community provided transport infrastructure is in place to support appropriate service provision across all fields.

Support moves to increase frequency and coverage of public transport.

2.5 AFTER HOURS MEDICAL CLINIC/BULK BILLING CLINIC

Assist member agencies verify or ascertain the needs for such clinics. Support action to help obtain an appropriate service taking into account local workforce issues.

OBJECTIVE 3 : DEVELOP A COORDINATED DELIVERY SYSTEM

3.1 INTERFACE ISSUES BETWEEN SECTORS

Focus on the Service Delivery and coordination needs in the Aged Care field and continue to engage local agencies within the PCP to undertake the collaborative work to deal with local Service Coordination issues which impact on quality service delivery – particularly the interface issues of consumer transitions between sectors (e.g. from acute to residential or community etc) and issues which reduce demand on acute facilities.

3.2 DEVELOP “COMMON” CARE PLANNING PROCESSES AND PROCEDURES

Develop processes and procedures, trial the use of the DHS Care Planning Tool Templates and encourage adoption of one common process throughout the service system.

3.3 COMMON CLIENT SERVICE “SYSTEM”

Continue to establish common client contact and delivery system across member agencies incorporating:

- quality initial contact processes,
- the DHS mandated IC/INI and Care Planning Tools,
- encrypted referral using HeSa Keys, and
- local common procedures, protocols and systems to operationalise and link all the above components.

3.4 DEVELOP LINKAGES AND COORDINATION STRATEGIES WITH AND BETWEEN AGENCIES PROVIDING PRIMARY CARE SERVICES TO UNDERSERVED POPULATION GROUPS

Seek to engage with Agencies providing services to indigenous Australians and persons of CALD backgrounds. Seek to obtain a more informed analysis of Women’s Health needs and issues and engage with agencies addressing these needs.

| |
|--|
| <p>OBJECTIVE 4 : IMPROVE CAPACITY TO DELIVER A RANGE OF RESPONSIBILITIES (INCLUDING HEALTH PROMOTION)</p> |
|--|

4.1 PLANNING AND STAFF CAPACITY BUILDING

Increase the capacity of agencies to undertake best practice Health Promotion on an ongoing basis through:

- training activity to enhance agency and agency staff capacity,
- increased provision of health promotion information, (both to providers and consumers),
- integrated service planning, and
- through participation in two demonstration programs in the field of mental health (information) and cardiovascular illness (physical activity).

4.2 HEALTH PROMOTION CAMPAIGN : MENTAL HEALTH

Develop an integrated campaign to increase the knowledge of members of the community about mental and emotional health issues and improve knowledge of services which respond to individuals with mental and emotional health problems.

4.3 HEALTH PROMOTION CAMPAIGN : CARDIOVASCULAR HEALTH

Develop an integrated “themed” campaign designed to increase the level of community activity and mobility through “**walking**” as a way of contributing to addressing a number of significant health issues such as Cardiovascular disease and Type 2 Diabetes.

5. ACTION STRATEGIES : CHP 2003/04

The following Action Plan relates to the Strategic Objectives set to meet the health and primary care needs and issues identified in this PCP catchment.

The Action Plan also reflects visions for the future by staff in PCP member agencies. In May 2003 twenty representatives of fifteen agencies attended an informal meeting to discuss a future **vision** of the Health, Community, Service and Primary Care System in the Northern Mallee and to create “snapshots” of the future. The snapshots of the service system which emerged from this meeting over which there seemed to be some consensus were as follows:

ONE COMMON SYSTEM

- A common “front end” of the service system that is easier for consumers and service provider staff to access and navigate – including common forms, referral procedures and processes for on going service delivery. This snapshot incorporated the widespread take up and use of the DHS INI/IC forms.

HIGH DEGREE OF ITS USE

- I.T. systems promoting a high level of connectivity between local Agencies and other relevant organisations. This includes secure IT based client record systems emphasising **Electronic Referral** used by all agencies (with smaller agencies subsidised to enable them to acquire the necessary training and technology). It also includes resourcing to enable service providers can get trouble shooting in respect of IT systems problems.

QUALITY ‘RECEPTION’ OF CONSUMERS

- A highly skilled and trained Initial Contact staff (including reception and intake workers) across all agencies in the service system so that initial contact for service consumers would be optimised.

QUALITY ‘POST RECEPTION’ CONTACT

- Highly skilled Intake staff and assessment in each agency who are performing a “SAO type” of role with excellent initial needs identification and information skills.

“ONE STOP” INFORMATION REPOSITORY

- A one stop “shop” – where the public can go to get multi modal information about and referral to services in the system. Including a central repository of data and health information accessible to all agencies.

INTEGRATION AND COORDINATION OF PLANNING PROCESSES

- More emphasis on planning coordination and integration – particularly of major plans. This involves integrating the existing plans into one Master Plan.

BETTER INTEGRATION/COORDINATION BETWEEN GPS AND OTHER PARTS OF THE SERVICE SYSTEM

- More integration between primary health services and GPs (who are the gatekeepers to the service system) with GPs having a critical coordinating role.

These snapshots, although not formally endorsed by this PCP as our vision for the future, provides an interesting background to the development of the Action Plan which was subsequently endorsed by Agencies.

OBJECTIVE 1 : BUILD COLLABORATIVE INFRASTRUCTURE

1.1 Integrated Planning

| WHAT | WHO | WHEN | KEY PERFORMANCE INDICATORS |
|--|--|-------------|--|
| 1.1.1 Determine a Strategy for integrated planning in the Northern Mallee including recommendations on the relationship of the CHP with the MPHP and with smaller sector plans such as Mental Health, Disability, Youth, Aged Care and HACC. | Secretariat Staff and Planning Working Group Staff | September | Strategy Plan presented to PCP Executive |

1.2 Improve Consumer Participation

| WHAT | WHO | WHEN | KEY PERFORMANCE INDICATORS |
|--|------------|---------------|---|
| 1.2.1 Review current level of Consumer participation in the development of PCP policies and procedure and recommend new or revised strategies to PCP Executive. Note also relevant in respect of 1.1.1 | E.O. | By March 2004 | A strategy document is presented to PCP Executive |

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1.3 Interagency Communication

| WHAT | WHO | WHEN | KEY PERFORMANCE INDICATORS |
|--|------------------------------------|------------------|--|
| 1.3.1 Continue to produce monthly PCP Newsletters and encourage agencies to use it extensively as an information exchange medium. | E.O. and Secretariat Staff | Monthly | (1) 12 monthly newsletters are produced. (2) During year, at least 10 agencies submit copy/content. |
| 1.3.2 Continue the development of the NMPCP Website, publicise it and encourage agencies to upload information and use it (particularly demographic, social and needs data). | Secretariat Staff PCP Executive | On going | At least 5 Agencies upload information or submit information for uploading. |
| 1.3.3 Determine marketing issues and marketing strategy to publicise the three major information communication vehicles (Newsletter, Website and Service Directory). | E.O. and PCP Executive | By December 2003 | A marketing strategy is developed. |
| 1.3.4 Continue to encourage Networks in their information sharing role and in encourage them to gradually take on a needs assessment, problem solving and planning input role. | Secretariat Staff CEO's | On Going | (1) Network information gets to NMPCP Newsletter (2) Networks consider adoption of ACPAC meeting model (3) CEO's support moves to encourage more of a problem solving planning role among staff from their agencies who attend networks. |

1.4 ICT Strategy Plan for Northern Mallee

| WHAT | WHO | WHEN | KEY PERFORMANCE INDICATORS |
|--|--|---------------|---|
| 1.4.1 Become actively involved in the decision making related to the Regional (Loddon Mallee) ICT Strategy Plan through its facilitative Governance Structure. | Northern Mallee Agencies who are represented on the Governance Group | On Going | Agencies represented on the governance body liaise closely with NMPCP Executive (through E.O. if necessary) and are aware of NMPCP ICT needs, policies and strategies as developed by NMPCP agencies. |
| 1.4.2 Publish an ICT Information paper addressing IT possibilities and ideals and issues of connectivity and IT Standards. | E.O. in conjunction with IT Working Party | August | Information paper |
| 1.4.3 Undertake a brief local mapping exercise to ascertain (current) IT readiness (building on existing work). | IT Working Party consultant | by March 2004 | A status report made available |
| 1.4.4 Conduct a forum on the Regional ICT Plan utilising speakers from outside the region who are familiar with its development – open to all local Agencies | Gregg Nicholls BHCG | July | Forum takes place |
| 1.4.5 Visit to SWARH (Warrnambool) by agency representatives to see Broadband connectivity in action | E.O. and at least 3 agency representatives | September | Visit takes place |

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1.5 Recruitment and Retention of Staff

| WHAT | WHO | WHEN | KEY PERFORMANCE INDICATORS |
|---|---------------------------|----------------------|--|
| 1.5.1 Continue work of the Recruitment Working Group to implement recommendations of the Recruitment and Retention Working Group (prioritise coalition building and preparation of information pack). | Recruitment Working Party | By end December 2003 | (1) A broader coalition of interested parties is created. (2) An information package about Mildura is produced. |
| 1.5.2 Continue to seek funding to employ a Support Worker to help implement Recruitment and Retention Strategy | Recruitment Working Party | On Going | (3) Staff resources are made available to assist with implementation |

1.6 Governance and Sustainable Partnership Development

| WHAT | WHO | WHEN | KEY PERFORMANCE INDICATORS |
|---|--|----------------------|--|
| 1.6.1 Continue to monitor and review the activities of the PCP and take steps to promote and increase collaborative activity. | PCP Executive and all PCP Member CEO's | On Going | Member agencies actively working to achieve NMPCP strategic objectives and participating in this plan. |
| 1.6.2 Continue to review (and modify as necessary) PCP Governance Structure to provide the best decision making and implementation processes. | PCP Executive | On Going | Attendance increases (Member agencies own the PCP process. Decision making is optimised.) |
| 1.6.3 Continue to develop the shared vision of NMPCP through opportunities for Member Agency CEOs to get together and discuss issues | PCP Executive | August then On Going | PCP sponsors a workshop for CEOs on shared vision. |

COMMUNITY HEALTH PLAN 2003/04

1.7 Service Information

| WHAT | WHO | WHEN | KEY PERFORMANCE INDICATORS |
|---|--|--------------------|---|
| 1.7.1 Employ a part time Content Manager (from PCP and member Agency contributions) to; systematically update cc.com, and to promote and publicise its availability | Secretariat to enable Recruitment Supervised by Service Access Working Party | July/August | Workers is engaged and located at PCP Office. |
| 1.7.2 Consider trialing a part time information service to selected service providers (possibly GPs) about local service availability. | Form Working Group : MDGP, Content Manager, MRCC | October – November | Proposal is developed and put to PCP Executive. |
| 1.7.3 Develop policy about content of local Directory and direct Content Manager accordingly | Service Access Working Party | August | A written policy statement is developed and endorsed by PCP Executive |
| 1.7.4 Continue to seek Agency contributions to fully fund the part time Content Manger position. | Secretariat ICW | Ongoing 2003/04 | All users have been requested for support. |
| 1.7.5 Develop an appropriate “user pays” strategy for Connectingcare.com content in the Northern Mallee for long term sustainability | Service Access Working Party | Ongoing 2003/04 | A strategy to ensure user agency ownership and ongoing viability of cc.com in Northern Mallee is developed. |
| 1.7.6 Continue to remain a member of the Statewide cc.com User Group | Secretariat | Ongoing | NMPCP views are put to group through regular attendance at meeting. |
| 1.7.6 Pay annual licence fee to MRCC to cover Web Hosting and ongoing developmental costs (\$6,000) | Secretariat | Ongoing | As above |

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| | | | |
|---|---|---------------------------------|--|
| 1.7.8 Investigate the need for the development and implementation of complementary information dissemination methods (e.g. Telephone, one stop shop, face to face). | Secretariat Service Access Working Party Agency Questionnaire | 2 nd Half of year | Agencies have had opportunity to give input into their preferred information dissemination method. A strategy paper is prepared for PCP Executive. |
|---|---|---------------------------------|--|

1.8 Improve and Support Capacity of the Service System to Respond to Opportunities, Gaps and “Threats”

| WHAT | WHO | WHEN | KEY PERFORMANCE INDICATORS |
|--|---|-------------|--|
| 1.8.1 Convene short term interagency focus groups and working groups to respond to opportunity and threats as identified by the PCP members. | Secretariat Staff and relevant stakeholders depending on the issue. | On Going | Short term groups are formed and deal with issues. |

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OBJECTIVE 2 : TAKE ACTION TO OVERCOME SERVICE GAPS

2.1 Counselling and Support Services

| WHAT | WHO | WHEN | KEY PERFORMANCE INDICATORS |
|--|--|-------------------|---|
| 2.1.1 Establish interagency working party to determine unmet needs for public counselling staff and current counselling staff availability | E.O., Centacare, SCHS, MFC, MDGPs, LMWH, and interested agencies | End December 2004 | A position paper is produced for PCP Executive. |

2.2 Aged Services for Independent Living

| WHAT | WHO | WHEN | KEY PERFORMANCE INDICATORS |
|---|--|-------------------|---|
| 2.2.1 Map the services supporting independent living in this area, ascertain needs that are unmet, determine an action plan to address the perceived needs including action to lobby for more services. | Service Coordination Working Party with E.O. in conjunction with ACPAC group | By January 2004 | A service map and report showing quantity of current contacts and waiting lists etc together with recommendations is presented to PCP agencies. |
| 2.2.2 Review adequacy of Community Aged Care Packages particularly in relation to Dementia Care | SRS in association with ACPAC and interested agencies | September/October | A position papers recommending action is presented to PCP Executive |

2.3 Youth Services

| WHAT | WHO | WHEN | KEY PERFORMANCE INDICATORS |
|---|------------|-------------|------------------------------------|
| 2.3.1 Encourage Agencies to implement items in the Youth Strategy Plan and update plan. | E.O. | On Going | Plan is used as a living document. |

COMMUNITY HEALTH PLAN 2003/04

2.4 Transport

| WHAT | WHO | WHEN | KEY PERFORMANCE INDICATORS |
|--|---|---------------------|---|
| 2.4.1 Support SunAssist in expanding its Service Delivery to meet gaps in the Northern Mallee | <ul style="list-style-type: none"> • NMPCP Executive • SunAssist staff • Work with Southern Mallee PCP | On Going | (1) A strategic plan is developed (2) Appropriate lobbying action takes place. |
| 2.4.2 Convene Agency meeting to discuss and quantify needs for subsidised transport in Northern Mallee and prepare Action Plan for PCP Executive | <ul style="list-style-type: none"> • E.O. • SunAssist staff • Interested agencies | August | Meeting takes place |
| 2.4.3 Determine unmet public transport needs and support action to increase availability of public transport. | NMPCP Executive and appropriate agencies e.g. MRCC, also LLEN and Transport companies. | Second half of year | (1) Production of a definitive report (2) Lobbying action by NMPCP. |

2.5 After Hours Clinic/Bulk Billing Clinic

| WHAT | WHO | WHEN | KEY PERFORMANCE INDICATORS |
|--|--|--------------|---|
| 2.5.1 Establish interagency working party to determine needs for an after hours GP clinic and for a Bulk Billing Clinic and make recommendations for action. | E.O., MDGP, Hospital and interested agencies | End November | A position paper is produced for PCP Executive. |

OBJECTIVE 3 : DEVELOP A COORDINATED DELIVERY SYSTEM

3.1 Service Coordination : Interface Issues

| WHAT | WHO | WHEN | KEY PERFORMANCE INDICATORS |
|--|---|---------------------------------|--|
| 3.1.1 Undertake a survey to ascertain specific issues and problems in service coordination between the major sectors e.g. Acute, Residential, GP, Primary care – emphasise Discharge Planning and Acute discharge. | Executive Officer in consultation with Service Coordination Working party and Base Hospital | September/October | A detailed and quantified explication of issues and problems is drawn up for PCP Executive |
| 3.1.2 Undertake if required, pilot programs to demonstrate ways of effectively dealing with problems/issues ascertained as part of the survey above. | Agencies as agreed | 2 nd Half of 2003/04 | Pilot Program being undertaken in collaborative way. |

3.2 Care Planning

| WHAT | WHO | WHEN | KEY PERFORMANCE INDICATORS |
|---|---|----------------|--|
| 3.2.1 Develop policy, processes and procedures for uptake of Care Planning tool template. | Service Access Working Party with PCP project officer | January 2004 | Documented procedures and process in place |
| 3.2.2 Pilot use of Care planning template in 3 agencies and possibly GP surgeries. | Service Access Working Party with PCP project officer | February 2004 | Pilot in place in 4 agencies. |
| 3.2.3 Review Case Conferencing proposal submitted unsuccessfully to DHS | E.O., MDGP | September 2003 | Decision made about whether to continue to pursue. |

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3.3 Common Client Service System

| WHAT | WHO | WHEN | KEY PERFORMANCE INDICATORS |
|--|---|--------------------|--|
| 3.3.1 Offer training and workshops to Agency Staff involved in Reception, Intake and initial needs identification in quality client practices and use of local electronic service directory. | Secretariat Staff Consultant MRCC staff | First half of year | At least 2 skills training workshops are run One Information session on Electronic Service Directory is run |

3.4 Linkages and Coordination Strategies (Underserviced Groups)

| WHAT | WHO | WHEN | KEY PERFORMANCE INDICATORS |
|--|-------------------------------|-------------|--|
| 3.4.1 Review Action Items in relation to Aboriginal Health set out in 2002/03 CHP. Carry these forward into 2003/04 plan. | E.O. DHS representative | September | Communication takes place with CEOs of both Aboriginal Co-operatives in respect of proposed items. |
| 3.4.2 Communicate with SECC regarding possible areas of collaborative and involvement to ensure CALD issues are addressed. | E.O. NMPCP E.O. SECC | September | Discussion is held. |

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OBJECTIVE 4 : IMPROVE CAPACITY TO DELIVER HEALTH PROMOTION

4.1 Health Promotion – Planning and Capacity Building

| WHAT | WHO | WHEN | KEY PERFORMANCE INDICATORS |
|---|---|--|---|
| 4.1.1 Continue to support Health Promotion Network approach (with agencies meeting monthly) to encourage broader participation of Agencies in collaborative Health Promotion activity e.g. Domestic Violence Agency, School Nurses, Education providers Police etc. Utilise the Health Promotion Network to drive the NMPCP H.P. Strategy | Health Promotion Working Party and Secretariat staff | All year | Attendance at Health Network meetings increased by 8 agencies/organisations. |
| 4.1.2 Employ an 0.3 Project worker to support the achievement of the Health Promotion committee objectives – particularly planning and capacity building | E.O. in consultation with HP Working Party | August | Position is established and located in a member agency (possibly combined with the other fractional positions in this plan – see 4.2.1 and 4.3.1) |
| 4.1.3 Formulate an agreed Strategy for the development of a Northern Mallee Health Promotion Plan which will provide the context to the Health Promotion activities of members of NMPCP and other members of the H.P. Network | Health Promotion Working Party and Secretariat staff including SCHS | <ul style="list-style-type: none"> • by end September 2003 | A strategy will be presented to the NMPCP Executive for endorsement. |
| 4.1.4 (Subsequent to 4.1.2 above) Develop a broad prioritised Northern Mallee Health Promotion Plan | Health Promotion Working Party | <ul style="list-style-type: none"> • by end May 2004 | The first area Health Promotion Plan is endorsed by PCP agencies |
| 4.1.5 Compile a 6 monthly Health Promotion Calendar and ensure this is well publicised via NMPCP website, NMPCP newsletter etc. | H.P. Project Worker | <ul style="list-style-type: none"> • by end September 2003 • by end March 2004 | Health Promotion Calendar is published in October and April each year. |

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| 4.1.6 | Resource Capacity Building by agencies through sponsorship of seminars and workshops and individual training of staff members. | Health Promotion Working party and H.P. project worker | On Going | 3 (no cost) seminars and workshops sponsored during the year. |
| 4.1.7 | Investigate options for integrating Health Promotion information sources into connectingcare.com or linked to NMPCP Website | Service Access working party E.O. | December 2003 | At least 10 Health Promotion sources e.g. Asthma Foundation are linked to connectingcare.com (or NMPCP Website). |

4.2 Health Promotion Campaign : Mental Health

| WHAT | WHO | WHEN | KEY PERFORMANCE INDICATORS | |
|-------|--|--------------------------------|----------------------------|---|
| 4.2.1 | Fund activity according to a Mental Health Promotion Plan developed by the Health Promotion committee. (information and education to promote mental and emotional health) (including an 0.3 support staff role) | Health Promotion Working Party | July 2003 | Plan to develop the strategy is to the satisfaction of funding body DHS |

4.3 Health Promotion Campaign : Cardiovascular Health

| WHAT | WHO | WHEN | KEY PERFORMANCE INDICATORS | |
|-------|--|--------------------------------|----------------------------|---|
| 4.3.1 | Fund activity according to a Cardiovascular Health Promotion Plan developed by the HP Committee (Increasing physical activity through themed walking campaigns) (Including an 0.4 Support staff role) | Health Promotion Working Party | July 2003 | Plan developed to the satisfaction of funding agency. |

4.4 Health Promotion Campaign : Suicide Prevention

| WHAT | WHO | WHEN | KEY PERFORMANCE INDICATORS |
|--|--|-------------|--|
| 4.4.1 Keep a watching brief on the Regional Suicide Prevention Strategy and relate this to (Mental) Health Promotion goals and plan. | Health Promotion Working Party E.O. | On Going | Relevant actions in the Regional Plan are reflected in Northern Mallee Plan. |

4.5 Rural Downturn Strategy

| WHAT | WHO | WHEN | KEY PERFORMANCE INDICATORS |
|---|------------|-------------|-----------------------------------|
| 4.5.1 Continue to assist in the coordination of assistance for those in Rural Areas affected by Drought Rural Downturn. | E.O. | As Required | Coordination group meets monthly. |

6. NMPCP RESOURCE INFRASTRUCTURE

NMPCP has organised its internal committee and working party structure and its central Secretariat support staff to best address achievement of our objectives as follows:

OBJECTIVE 1 : BUILD COLLABORATIVE INFRASTRUCTURE

- Recruitment and Retention Working Group (Existing)
- I.T. Working Group (Existing but dormant)
- Integrated Planning Working Group (Existing)
- NMPCP Executive (10 Agencies) (Existing)
- NMPCP Advisory Forum (Existing Forum) (21 Agencies)

Support Staff : 1.00 EFT Executive Officer (Existing)

0.5 EFT Service Directory Content Manager (to be appointed)

OBJECTIVE 2 : TAKE ACTION TO OVERCOME SERVICE GAPS

- Service Coordination Working Party (Existing)

Support Staff : 0.6 EFT Project Worker (Existing)

OBJECTIVE 3 : DEVELOP A COORDINATED SERVICE SYSTEM

- Service Access Working Party (Existing)

Support Staff : 0.5 EFT Project Worker (to be appointed)

OBJECTIVE 4 : IMPROVE CAPACITY TO DELIVER HEALTH PROMOTION

- Health Promotion Working Party (Existing)

Support Staff : 1.00 EFT Worker or equivalent in contracted input (Recommended)