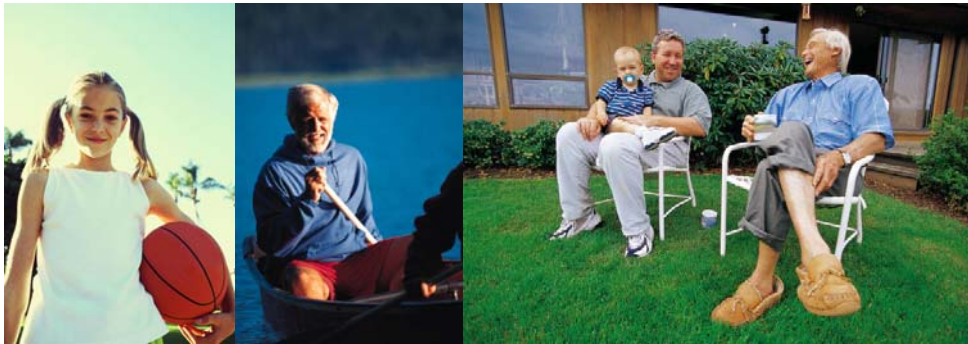


Wellington
Primary Care Partnership

COMMUNITY HEALTH PLAN
2004 – 2006



Wellington

Acknowledgments

The Wellington Primary Care Partnership is a voluntary partnership of 30 health and community based agencies in Wellington Shire.

The 2004/06 Community Health Plan is the result of a coordinated effort by the members of Wellington Primary Care Partnership who have come together to identify and address priority health issues for the Wellington region using a population health approach.

Our members are:

Anglicare	Latrobe Community Health Service
Arthritis Victoria	- Aged Care Assessment Team
Baptist Community Care	- Co Care Gippsland
Central Gippsland Health Service	- Commonwealth Carer Respite Centre
Dargo Bush Nursing	Latrobe Regional Hospital Mental Health Service
deaf access Victoria	Mental Illness Fellowship (Victoria)
Dental Health Services Victoria	Migrant Resource Centre
Department of Education and Training	Monash University School of Rural Health
Department of Human Services	MS Society Victoria
Department of Veteran Affairs	Oz Child
Diabetes Australia	Ramahyuck District Aboriginal Corporation
East Gippsland Division of General Practice	Royal Victorian Institute for the Blind
Eastern Gippsland Arts and Recreation	Special Needs Access Program
Access Group	Villa Maria Society
Gippsland Centre Against Sexual Assault	Vision Australia
Gippsland Women's Health Service	Wellington Shire Council
Gippsport	Wellington Special Needs Network
Kilmany Uniting Care	Yarram and District Health Service

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Introduction

The 2004/06 Community Health Plan highlights the direction of Wellington Primary Care Partnership for the next two years based on the Department of Human Services Primary Care Partnership Strategy 2004-2006. This plan will build on the foundations and achievements of the previous two community health plans.

Integrated Health Promotion and Service Coordination continue to remain the two key deliverables for Primary Care Partnerships with a focus on building the strength and capacity of member agencies to work collaboratively within a given catchment.

As in previous years, the work of Wellington Primary Care Partnership will continue to be underpinned by the social model of health, with a focus on reorienting the primary care system to become population focused.

The 2004/06 Community Health Plan will focus on three priority areas: Integrated Health Promotion, Service Coordination and Consumer Participation.

The Plan begins by outlining the vision and shared values of WPCP. During this year's strategic planning process the vision and values of Wellington Primary Care Partnership were open to revision. Members agreed that the vision of WPCP should continue to be based on the Ottawa Charter's Health Promotion Framework 1996. Our shared values will continue to shape the 2004/06 Community Health Plan by espousing the importance of adopting a wholistic approach to health.

The Community Health Plan provides an overview of the achievements of Wellington Primary Care Partnership over the past twelve months and provides examples of our work in the form of two case studies.

The second part of the Plan identifies the priorities and strategies for WPCP for the next two years with a particular focus on Integrated Health Promotion.

The Integrated Health Promotion Summary Grid builds on the work of previous years by focusing on physical activity and nutrition. Mental health is an additional priority area that will enable our health promotion strategies to have a wholistic approach to health and well-being.

Vision

“Together we will enhance Health Opportunities and Outcomes for the communities of Wellington.”

We will achieve our vision by working within the Ottawa Charter Health Promotion Framework 1996, which states that:

“Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy need, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to well being.”

Shared Values

The shared values espoused by the Wellington Primary Care Partnership which underpin health promotion and establish a platform for enhanced service coordination are:

- adoption of a **social model of health** which provides a context for the development of the Health Promotion Strategy.
- a focus on **creating a healthy community**, emphasising support for personal choices for better health, and progress towards safer, healthier and more supportive living and working environments combined with improved personal health care and personal preventive services.
- an approach for promoting health and reducing the burden of illness should be **holistic**, encompassing the continuum of care from prevention through to treatment, management and rehabilitation.
- fostering partnerships, alliances and collaboration among different sections within the health and community sector; across other sectors; with community and non-government organisations and consumers to enable cross sector/agency integration and co-ordination.
- developing programs and services that achieve health advancement underpinned by appropriate evidence based research.
- supporting local communities to plan, develop and deliver health promotion programs and interventions that are specifically tailored to the needs of specific groups within the community.
- recognition that the objective of undertaking joint health promotion activities across the Partnership requires changes at both the systemic and service delivery levels, sustained effort, longer periods of time and multifaceted approaches.
- building on the exciting platform of service, resources and infrastructure for health promotion and public health.

Background

During the past twelve months Wellington Primary Care Partnership has continued to support the reorientation of the primary care system to be population-focused and underpinned by the social model of health.

Member agencies are continuing to strive for a common planning framework with organisational and service delivery plans being developed in tandem.

Health Promotion

2003-2004 saw a shift in planning for WPCP from a disease focus to a population health approach. A population health approach had been lacking in WPCP's integrated health promotion work and the 2003-2004 health promotion plan aimed to not only prevent and reduce the incidence of disease, but to start to create environments where people can be supported and encouraged to lead healthier lives.

The 2003-2004 Integrated Health Promotion Plan focused on three key areas:

1. Improving the health of primary school students and their families by improving nutrition and increasing participation in physical activity through active play and transport both in the school and at home.
2. Engaging communities to explore opportunities for recreation through the identification of local needs.
3. Creating safe and supportive physical environments that assist people in Wellington to live active and healthy lives.

Key achievements for 2003/04:

- Provision of funds to Central Gippsland Health Service to develop the Body Friendly Schools Program, which aims to increase the capacity of primary schools to create and implement healthy eating, physical activity and body image policies and practices within the whole school community.
- Provision of workforce development opportunities for member agencies to increase knowledge and improve practice with regard to the promotion of physical activity and healthy eating.
- Development and implementation of the Walking School Bus Program in four primary schools in Sale.
- Supporting Wellington Shire Council to actively embrace a population health planning approach by providing workforce development opportunities that focus on 'Healthy Urban Environments' and the 'Environments for Health Framework'.
- Working in partnership with local secondary colleges, East Gippsland Institute of TAFE, Gippsport, local sporting clubs and Wellington Shire Council to expand the Maffra Future Leaders Program.
- Increasing the capacity for WPCP member organisations to develop collaborative strategies.
- Educating staff about the social model of health and the principles of health promotion.

Integrated Health Promotion Case Study: Walking School Bus Program

“To encourage active living within Wellington communities through the development of safe and supportive environments for physical activity.”

Introduction

As part of the Wellington Primary Care Partnership focus on health promotion, emphasis has been placed on the importance of addressing healthy eating and physical activity as opportunities for health gain. This has resulted in the development of a number of programs, each concentrating on a particular aspect of improving nutrition or increasing participation in physical activity in Wellington that together will serve to improve the health of the community.

A priority goal has been to address the declining physical activity levels and increasing obesity levels of primary school children.

A high percentage of primary school students are driven to school, even when the distance travelled is less than 1 kilometre. This is seen as a lost opportunity to be physically active.

The Walking School Bus program was seen as an opportunity to incorporate physical activity into the daily culture of schools and the community.

VicHealth and Wellington Primary Care Partnership allocated funding to Wellington Shire Council to engage a 0.9EFT project officer to implement the Walking School Bus project in four primary schools across Sale. The schools involved in the project are: Araluen Primary School, Sale '545' Primary School, St Thomas' Primary School and Guthridge Primary School.

Key Stakeholders

Araluen Primary School: parents, students and staff
Sale 545 Primary School: parents, students and staff
Guthridge Primary School: parents, students and staff
St Thomas' Primary School: parents, students and staff
East Gippsland Road Safe
Sale Neighbourhood Watch
Local Businesses
Wellington Shire Council
Wellington Primary Care Partnership
Sale Police
Volunteer walkers

Implementation

Implementation for the project involved:

- Appointment of a project officer.
- Formation of a steering committee comprising representatives from key stakeholder group.
- Information sessions at each school involving school councils, parent groups and other interested community members.
- Distribution of brochures and a survey to each school to ascertain interest in the program.
- Distribution of brochures to community organisations such as church groups and service clubs to ascertain interest in volunteering for the program.
- Interview and selection of prospective volunteer 'bus drivers'.
- Training of volunteers.
- Development of bus routes, leader rosters and behaviour guidelines.

- Volunteer committees established in each school.
- Program launch and commencement in March 2004.

Initial discussion with school principals was crucial to the success of the program. With their support, they gave approval to promote and advertise the program to the school community and permission to survey parents and students, allowing a stronger sense of ownership to develop within each school.

Outcome

There have been several successes of the project to date such as the tremendous response from the community indicating their willingness to be volunteers for the program. Some volunteers did not have children attending a school, but felt it was a valuable community program that they wanted to contribute to.

There has been strong cooperation from the schools to assist in promoting the program internally to teachers, parents and students. A pre-program survey indicated that a high level of students wanted to walk to school on the bus, and a high rate of parents were prepared to allow their children to walk with the school bus.

An important component of the process has been the implementation of the program in a community development framework. The focus has been to encourage the school and the community to have a high level of ownership of the program to ensure the sustainability of the Walking School Buses after the project funding ceases.

The program has been assisted by positive media promotion that has allowed a higher awareness of the program to be generated throughout the community.

It is evident that the success of the program is based on the strength of volunteer and school support. Without the volunteer drivers there would be no capacity to actually implement the program.

Conclusion

The Walking School Bus program has produced some very positive results even prior to the launch of the first operating bus. There have been newly formed partnerships and working relationships between Wellington Shire Council, Wellington Primary Care Partnership and school communities that had previously been very limited. This has opened the way to new opportunities for health promotion targeted at primary school communities.

Discussions have already begun with schools from other districts in Wellington about the potential to establish Walking School Buses within their area. This is very encouraging for Wellington Primary Care Partnership to see the expansion of this community based and owned physical activity program.

To help facilitate the expansion of the program, an information kit detailing the key learnings of the pilot program, along with guidelines for the process and suggested timelines associated with the establishment of the program has been developed. This kit also includes a DVD that has all the relevant training components that volunteers must undertake to become accredited drivers.

Service Coordination

Integrated Service Coordination continued to be a key outcome area for the Wellington Primary Care Partnership during 2003/04.

The Wellington Primary Care Partnership has a Service Coordination Advisory Group that is committed to improving access, responsiveness and integration of services in Wellington so that consumers and carers

- experience enhanced engagement with the services system and
- services are provided in a seamless, coordinated way.

The Wellington Primary Care Partnership Service Coordination priorities for 2003/2004 were based on an opportunity to build on service coordination activities both within Wellington and across the region.

1. GP engagement in BATS
2. Regional Service Coordination
3. Primary Health/Acute Interface.

With the introduction of the Better Health Care in Gippsland Project, service coordination work over the past twelve months has been focused on this regional project. The Service Coordination Advisory Group has devoted its energies to setting up links and protocols between WPCP and the Better Health Care in Gippsland Project. Wellington Primary Care Partnership has representatives on both the Service Coordination Working Group and Chronic Disease Management Working Group for the project. These working groups have been charged with the responsibility of developing a region wide approach to coordinated health care across the continuum of care, with a particular focus on chronic disease management.

PCPs in Gippsland have also established a formal partnership with the Gippsland Health Alliance with representation on the GHA Steering Committee and Service Coordination Task Group. Gippsland Health Alliance is responsible for the development of the Gippsland Regional Knowledge Portal, which is yet to become operational.

Key Achievements for 2003/04:

- Commitment by Central Gippsland Health Service, as the major acute service provider in Wellington, to work with WPCP members to use SCoTT and Wellington Primary Care Partnership protocols across the Division of Acute Services.
- Workforce development for Wellington Primary Care Partnership members regarding process and implementation of SCoTT.
- Formal partnership with the Better Health Care in Gippsland Project.

Integrated Service Coordination: Better Health Care in Gippsland Project

Project Description

The Better Health Care in Gippsland Model involves multiple linked components that together will deliver a region wide approach to coordinated health care across the continuum of care, particularly for people with chronic and complex needs. The project will build on and leverage off existing activities across the region at Commonwealth, State and Regional levels.

Project Scope

The project will involve a number of key components that address the aim of the project which is:

Aim

To improve the quality of care and quality of life outcomes for people who have and or are at risk of chronic illness.

Target Group

Elderly people and people with chronic and complex conditions, particularly those at risk of avoidable hospital admission.

Expected Outcomes

- Improved levels of satisfaction for people using the health care system.
- Reduction in problems with care coordination.
- Improved access to services for those in need through improved care pathways and navigation of the service system.
- Improved referral and discharge (reduction in referral “bounces” or dead ends).
- Reduced duplications in information collection.
- Better integration of General Practitioners into the broader primary care sector.
- Reduced preventable hospital admissions/readmissions.
- Increased utilisation and engagement with appropriate services.
- Increased ability of clients to self manage their condition.
- Improved health related quality of life/life functioning/ability to participate in activities.
- Increased satisfaction with care coordination.
- Increased levels of appropriate assessment, care planning, referral, screening and follow-up.
- Transferability and dissemination of key learning’s and possible state-wide adoption of project components including the regional approach to service coordination.

Project Components

The project builds on existing partnership arrangements and existing Regional collaborative work, to deliver an integrated regional approach to primary care service delivery based on a region-wide governance structure. At the core of the project are four linked, interdependent and complementary areas of work that support integration and coordinated delivery of care. The main areas of project activity are:

- Continued support for a Partnerships approach within the Gippsland Region.
- Establishment of a region-wide governance structure, building on partnership and collaborative arrangements.

- A region wide approach to the integrated delivery of primary care services, incorporating:
 - Development and implementation of a region-wide approach to service coordination (building on the work of individual Primary Care Partnerships), to support key areas of integration across hospitals, GPs, and other key primary care providers;
 - Extending this region-wide approach to service coordination to develop and implement a region-wide model for the care of people with chronic and complex needs;
 - Building on the service coordination work and extending the chronic and complex needs management model to develop a generic Care Pathway Protocol and implement this in trial sites in relation to a specific agreed health priority; and
 - Building on the service coordination work to develop and test an agreed mechanism for determining risk, eligibility and priority within a primary care setting.

- Support this project work through a change management approach which builds on the existing change management approach underpinning the PCP Strategy, and learning from other examples of region-wide implementation.

- An evaluation framework that collects baseline data and aims to measure process, impact and outcome indicators related to improved integration.

Project Context

There are four Primary Care Partnerships in the Gippsland Regional, covering one or two local government areas. Each PCP aims to improve the health and well-being of their catchment's population by better coordination and planning and service delivery in response to identified needs. Each has a broad membership consisting of hospitals (many of which also provide significant primary care services), community health centres, local government, Divisions of General Practice, and a range of other service providers as relevant in the local service system.

These partnerships have been developing and implementing common local practices, processes and protocols to integrate the way in which consumers come into contact with the service system, how needs are identified and assessed and the way in which care is planned and managed. This work will be brought together to develop and implement a region wide approach to service coordination. Reports from Primary Care Partnerships indicate a high level of use of the 'core' Service Coordination Tool Templates by Department of Human Service funded agencies. This includes high levels of uptake in the acute hospital environment in some health services.

The four Primary Care Partnerships already collaborate in particular ways on joint goals for improving the primary care service system.

The Primary Care Partnership Strategy incorporates the key success factors identified for effective GP-Hospital Integration initiatives, that is:

- Involving all stakeholders
- Managerial and clinical leadership
- Stakeholders and change agents have a sense of ownership in the initiative
- Engaging General Practitioners
- Having a well developed plan (with some capacity for flexibility)
- Identifying possible outcomes from the start and setting up evaluations to measure them.
- Effective communication
- Using evidence based models and tools
- Having strategies to embed change and ensure sustainability
- Sharing tools and findings.

The PCP Strategy provides both State level policy direction and is supported by resources for local programs. The initiatives themselves reflect the local context and are supported by local collaborations. A mutually reinforcing scenario of this kind is described as ideal for GP-Hospital Integration activity.

Project Milestones

Date	Milestone
April 2004	Project initiation and engagement of consultant
April 2004	Regional governance structure in place
April 2004	Stocktake of progress on existing work on health sector integration and coordination completed and regional work plan and priorities agreed
By 30th April 2004	Management of people with chronic & complex needs working group and consumer reference groups established
By 30th April 2004	Evaluation specifications developed
By 31st May 2004	Independent evaluator appointed
By 30th June 2004	Baseline data collection complete
By 31st July 2004	Care pathway working group established
September 2004	Region-wide protocols, practices and processes for service coordination agreed to and implementation begun
November 2004	Chronic and complex protocol developed
By 24th December 2004	Development of risk, eligibility, priority tool/instrument, and training material
December 2004 – May 2005	Chronic and complex protocol 9 month pilot
By 28th February 2005	Development of protocol for use of the risk, eligibility, priority tool/instrument
March 2005	Care pathway protocol developed
March 2005 – May 2005	Primary Care Triage Pilot – 3 months
May 2005 – January 2006	Care Pathway Pilot – 9 months
31st March 2006	<ul style="list-style-type: none"> ▪ Final evaluation report completed ▪ Findings from trial sites used to inform extension of implementation within Gippsland region and other areas of the state.
31st March 2006	Project Completion

Directions for 2004/06

The 2004/06 Community Health Plan is underpinned by the following planning documents:

- Wellington Shire Council Municipal Public Health Plan 2004-2007 (in development)
- Wellington Primary Care Partnership Community Health Plan 2003-2004
- Victorian Population Health Survey
- DHS Community Data Sets
- National and State Health Priority areas.

In particular, our plan is influenced by the Wellington Municipal Public Health Plan which addresses the social determinants of health, which are the social, economic, built and natural environments of communities that influence the social, psychological and lifestyle factors for the residents of Wellington Shire.

Three key priority health promotion topics for 2004/06 in Wellington have been identified following a strategic planning process. These are:

- Physical Activity
- Nutrition
- Mental Well-being and Social connectedness

These priorities have developed from a number of sources.

Firstly, input was sought from member agencies about needs, issues and service gaps. The input was derived through consultation at a Strategic Planning day held in July 2004 and during subsequent Health Promotion Working Group meetings. These planning processes identified the need to build on the activities that had begun during previous years around promoting physical activity and healthy eating to primary school children and the wider school community.

Increasing issues around mental health and well-being for our young people and the demonstrated relationship between physical activity, healthy eating and social connectedness on health led to mental health becoming an additional priority topic for the 2004/06 plan.

Several member agencies identified the need to address the health and well-being needs of older adults in Wellington. Again, it was agreed that a holistic approach, looking at the promotion of physical activity, healthy eating and social connectedness to this target group would result in enhanced health opportunities and outcomes for adults over 45 years of age.

Operational Plan 2004/06

The Operational Plan will set out the activities to be undertaken by Wellington Primary Care Partnership over the next two years. This plan will require further detailing through the development of specific action plans and work groups that will address the three key priority areas.

In developing the operational plan, WPCP has sought to:

- Build on the achievements of WPCP.
- Strengthen our understanding of the communities we serve through the use of the updated Wellington Shire Council Community Profile, which provides detailed profiles for each catchment within Wellington. Refer Appendix 1.
- Identify health priorities based on this profile and the priorities identified in the Municipal Public Health Plan, taking into consideration emerging issues within the community.
- Identify the existing health promotion plans, programs and projects that are operational within the Wellington area and develop strategies which build on these.
- Use an evidence based approach to identify appropriate strategies to address the priority areas.
- Refer to appropriate local, State and National policy and planning documents to inform priority and strategy setting.

Priorities for Action

In 2004/06 the Wellington Primary Care Partnership will focus on the priority areas of:

- Integrated Health Promotion: Physical Activity, Nutrition and Mental Well-being.
- Service Coordination: Better Health Care in Gippsland Project and Transport.
- Consumer, Carer and community participation.

Strategies

Problem Definition

GOAL:

To improve the health and well-being of Wellington communities through healthy eating, physical activity and mental health promotion.

OBJECTIVES:

To encourage active living within Wellington through physical activity promotion.

To promote healthy eating in the Wellington Shire.

To enhance the mental wellbeing of the communities in Wellington

POPULATION TARGET GROUP(S):

Young people (with a particular focus on primary school aged children 5 -12 years)

Older Adults aged 45+

Solution Generation

EVIDENCE BASE

Community Consultations undertaken by Wellington Shire Council identified seven key areas of concern within the Wellington community: Cardiovascular Disease, Diabetes, Family Violence, Social Isolation, Transport and Mental Health. These issues are consistent with National and State priority areas and can be addressed through interventions such as those outlined in documents such as "Planning for Healthy Communities: Reducing the risk of cardiovascular disease and Type 2 Diabetes through healthier environments and lifestyles".

There is a wide range of evidence to support health promotion activities that improve the mobility of older adults. In particular, increasing physical activity is a well recognised approach in the prevention of falls, diabetes and cardiovascular disease for the older population. Initiatives such as COTA's Living Longer Living Stronger program and VICFIT's Active for Life program demonstrate the positive impact that physical activity can have on the overall health and well-being of this target group.

The impact of physical activity and nutrition on the health of young people is an important issue as rising levels of obesity remain a key priority area at a local, national and global level. The Commonwealth Government's Healthy and Active Australia initiative aims to address the increasing sedentary levels of primary school children as well as promoting the benefits of good nutrition. This initiative supports the work that Wellington Primary Care Partnership has started through the Body Friendly Schools Program and will continue during this plan.

A population health approach has been used in the planning process and has provided an underpinning commitment to the notion of investment for health throughout the plan. There continues to be a strong evidence base for combined healthy eating and physical activity promotion programs, and combined with local examples of best practice, has formed the development of the 2004/06 Community Health Plan.

HEALTH PROMOTION INTERVENTIONS

Objective 1: To encourage active living within Wellington through physical activity promotion

Strategy Objective	Actions	Key Stakeholders	Process Evaluation Questions	Resources
1.1 Implement the Active at any Age Project to improve the physical activity levels of older adults	1.1.1 Investigate the possibility of offering additional aqua exercise classes for older adults.	CGHS Maffra Aquatic Centre	No. of programs No. of participants	\$12,000 (depending on success of HALS submission)
	1.1.2 Promote the physical activity guide through the Active Script program.	WSC EGDGP EGARAG Gippsport WPCP Hp Coordinator	No. of GPs utilising Physical Activity Guide	\$5000
	1.1.3 Provide opportunities for older adults to undertake State accredited training to offer physical activity programs in local areas.	Neighbourhood Houses WSC Gippsport	No. of people trained. No. of participants in physical activity programs.	\$2000

1.2 Support the implementation of the Fun Links to Fitness Program	1.2.1 Promote the Fun Links to Fitness program to women across the Shire to encourage greater participation in physical activity.	EGARAG GWHS WPCP HP Coordinator	No. of participants	\$5000
1.3 Develop Physical Activity Guide Resource.	1.3.1 Identify local opportunities for physical activity. 1.3.2 Finalise content of guide. 1.3.3 Develop online format. 1.3.4 Print 5000 copies of PA Guide. 1.3.5 Widely promote and distribute guide across Wellington Shire.	WSC Gippsport EGARAG WPCP HP Coordinator	No. of copies distributed.	\$15,000
1.4 Implement Walking School Bus program across Wellington Shire.	1.4.1 Support primary schools in local communities to implement WSB based on Sale model.	WSB Project Officer WPCP HP Coordinator	No. of schools implementing WSB program	
1.5 Implement the Wellington Future Leaders Program in Sale and Yarram	1.5.1 Engage school communities to participate in project. 1.5.2 Support project officer to implement program.	Maffra, Sale and Yarram Secondary Colleges Local Primary Schools WSC East Gippsland TAFE	No of participants in leadership program. No. of participants in after school program.	
1.6 Implement 10,000 Steps Wellington Promotion.		Gippsport WSC WPCP HP Coordinator	No. of participants in program	\$3000

Objective 2: To promote healthy eating in the Wellington Shire.

Strategy Objective	Actions	Key Stakeholders	Process Evaluation Questions	Resources
2.1 Facilitate a canteen forum for local schools	2.1.1 Engage representatives from local schools to participate in canteen forum. 2.1.1 Engage presenters for canteen forum to promote healthy eating in schools.	CGHS Local schools WPCP HP Coordinator	No of participants at forum.	\$5000
2.2 Develop local resource for schools based on Body Friendly Schools Project.	2.2.1 Work with schools involved in BFS program to develop school resource. 2.2.2 Promote resource to all schools within Wellington. 2.2.3 Support schools to utilise resource.	CGHS Local primary schools WPCP HP Coordinator	No. of schools utilising resources.	

Objective 3: To enhance the mental well-being of the communities in Wellington

Strategy Objective	Actions	Key Stakeholders	Process Evaluation Questions	Resources
3.1 Develop pilot 'Healthy Lifestyle Program for Schools'.	3.1.1 Investigate interest in program from local schools. 3.1.2 Identify target catchment. 3.1.3 Work with catchment to develop pilot program tailored to school needs.	SFYS DEET CGHS WPCP HP Coordinator	No of schools involved in pilot.	\$5000
3.2 Investigate the needs of young carers in Wellington.	3.2.1 Employ project worker to engage young carers and map needs. 3.2.2 Develop strategies to address needs of carers.	Project worker	No. of young people engaged.	\$5000

Service Coordination

During 2004/06 Wellington Primary Care Partnership will be committed to working in partnership with the Better Health Care in Gippsland project. Detailed work plans have been developed with the aim of fostering a region wide approach to coordinated health care across the continuum of care, with a particular focus on chronic disease management.

Other service coordination strategies will focus on improving access to transport for service users. Transport is continually being raised as a barrier to accessing health services and participating in broader community life. The Let's GET Connected Project has identified a number of transport issues faced by Wellington and East Gippsland service providers. As a result this project is looking at creative ways of improving transport options for service users across Gippsland. WPCP will support the project by undertaking a number of activities.

Key Activities:

- Through the Better Health Care in Gippsland Project ensure the inclusion of transport in relevant assessment processes and protocols.
- Work with the Division of General Practice to better coordinate client referrals for people who are case managed and have no access to vehicles.
- Coordinate planned activities and health programs around access to existing transport.
- In partnership with the Let's Get Connected Transport project and the HACC Pilot Project Partners:
 - Improve the data collection process of health related transport in order to identify gaps in the system and better coordinate existing resources.
 - Trial a web-based booking system to improve coordination of client travel and transport resources.
 - Encourage the health sector to work in partnership with existing transport providers in order to explore the possibility of becoming 'purchasers' of transport rather than providers of transport.

Resources:

- Member commitment and in-kind support.

Consumer Participation Strategy

The participation of consumers and carers in the design, planning, implementation and evaluation of primary care services has become a key priority in recent years. Based on the need to enhance the quality and effectiveness of consumer and carer engagement, Wellington Primary Care Partnership and East Gippsland Primary Care Partnership engaged the services of Kilmany Uniting Care to develop a Consumer and Carer Charter.

The Wellington Primary Care Partnership Consumer and Carer Charter was launched at the East Gippsland Consumer and Carer Conference during July 2004. Based on the content of the charter and the evidence presented at the Conference it was determined that Wellington Primary Care Partnership needed to develop a Consumer, Carer and Community Participation Strategy.

Key Activities:

- Undertake a mapping exercise of WPCP member's current policies and procedures.
- Endorsement of resources/policies for consumer, carer and community involvement by all member agencies.
- Capacity building workshop for service providers.
- WPCP to support and participate in the Youth Action Research Project.
- Development of a Young carers project.

Resources:

- Member commitment and in-kind support
- \$2000 for Capacity Building Workshop
- \$5000 for Young Carers Project.

Appendices

Appendix 1: Wellington Shire Council Community Profile 2003

Appendix 2: Integrated Health Promotion Summary Grid