



# ISEPICH Partnership Plan 2006 - 2009

*The vision for 2007 and beyond...*

**December 2006**

**Endorsed by PCP Chair:**

Name: Robbi Chaplin, Signature:  
Date: 21 December 2006

A handwritten signature in black ink, appearing to read 'Robbi Chaplin', is written over the signature line.

# Partnership vision

## Introduction

*The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being...* (Preamble to the WHO Constitution). ISEPICH recognises and seeks to promote health as a universal right. Founded on the social model of health, ISEPICH's vision is: "To create and maintain an accessible, responsive and integrated local primary health and community support service system that takes a planned approach to identifying and addressing community need."

In spite of the significant improvements in the health status of most Victorians over recent decades the ISEPICH catchment is home to some with the poorest health and lowest life expectancy – addressing the marked health inequalities which exist in the population of the Cities of Glen Eira, Port Phillip and Stonnington is without doubt the greatest challenge facing ISEPICH.

ISEPICH's vision is to create an integrated health and community services care system, based on partnerships, where providers see planning and working together to meet the needs of their communities as part of their core business. Integral to this process is the meaningful participation of consumers, carers and community members in all aspects of ISEPICH's operations.

In early 2007 the ISEPICH Executive will commence a process of reviewing the partnership arrangements and processes used for facilitating collaboration between member agencies. This process will include reviewing ISEPICH's membership structure, existing committee and working group processes, memorandum of understanding and good governance guide. This process will take into account other local partnership structures including:

- HARP/CDM Programs;
- Inner South East Area Health Council;
- Bayside Health Primary Care and Population Health Advisory Committee;
- Inner South Mental Health Alliance;
- The Inner South East District Planning Group; and
- The Area Based Planning Network (to be established as part of the Care in Your Community Strategy)

ISEPICH's 2006 – 2009 Partnership Plan will build the capacity of member agencies to work collaboratively in the following key areas:

## **Integrated Health Promotion**

The key activity will be the development, implementation and evaluation of a catchment plan for Integrated Health Promotion, which is evidence-based and effectively engages relevant organizations around the following priorities:

- Mental wellbeing
- Physical activity
- Nutrition and food security.

This process will take a population health approach<sup>1</sup> with two key goals: to maintain and improve the health status of the entire population, and to reduce inequities in health status between population groups. A key challenge is to establish shared responsibility and accountability within all levels of the health sector, including Bayside Health and General Practice, and outside the health sector.

This will involve bringing relevant stakeholders together to determine the scope of interventions and apply a mix of strategies in an integrated way, over the life span, in multiple settings, for different population groups, including both short and longer term interventions. This process includes selection of best 'investment' on basis of:

- Magnitude of the issue (severity, economic burden)
- Status of current response (what is being done)
- Ability to effect change (address more than one issue, timing, capacity etc)
- Appropriateness for involvement (whose role, is there support etc)
- Cost effectiveness

In particular the ISEPICH Executive will seek to facilitate senior leadership within member organizations to address the up-stream determinants of health.

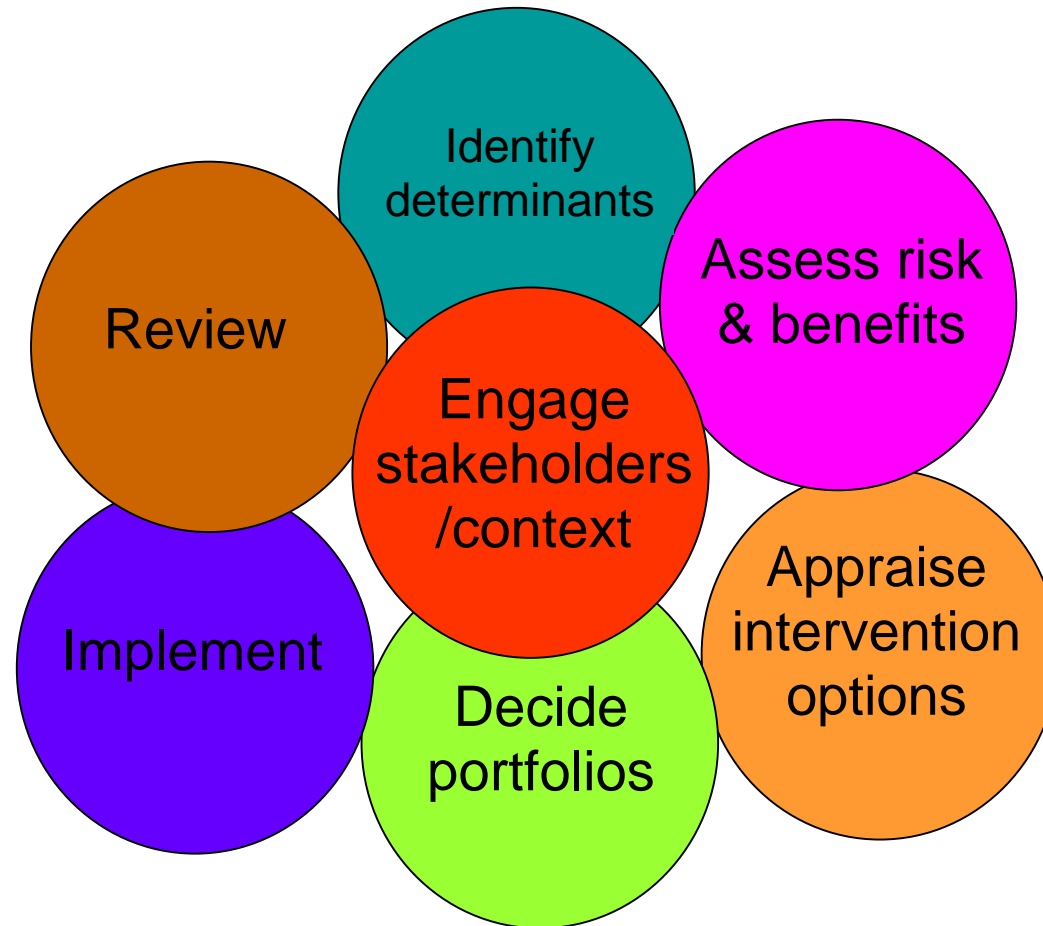
ISEPICH's health promotion priorities were agreed by members and community representatives at a planning forum in May 2006. ISEPICH's integrated health promotion catchment planning process will be guided by the framework developed by the National Public Health Partnership 'Deciding and Specifying an Intervention Portfolio'<sup>2</sup> (see diagram on the following page).

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<sup>1</sup> Population health refers the health of a population as measured by health status indicators and as influenced by: social, economic and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development, and health services.

<sup>2</sup> National Public Health Partnership (NPHP) *A Planning Framework for Public Health Practice* NPHP, Melbourne 2000. Available at <http://www.nphp.gov.au/publications/phpractice/planfrwk.pdf> (accessed 5 December 2006).

# National Public Health Planning Framework



## **Service Coordination & Chronic Disease Management**

ISEPICH's service coordination strategy aims to improve access, responsiveness and integration of the system to ensure that services are provided in a seamless, co-ordinated way and that consumer and carer outcomes are enhanced. The strategy aims to re-orient health services to take a health promotion approach, focusing on prevention and early intervention for at-risk individuals and groups, minimising the onset of disease and preventing hospital admissions.

ISEPICH member agencies will work together to ensure that the service coordination strategy has a strong emphasis on supporting people with chronic disease. This approach will engage people with chronic illnesses as partners in their own care and will actively engage relevant organisations, including Bayside Health and General Practice, to ensure that best practice approaches are pursued in relation to self management, early intervention and treatment of people with chronic illness.

## **Reducing Health Inequality**

As noted above the ISEPICH catchment is characterised by marked health inequalities. Although many ISEPICH member agencies and other local organisations have developed innovative approaches to service delivery and health promotion programs, there is considerable scope to improve intersectoral and inter-organizational collaboration in addressing health inequality. ISEPICH's approach is based on a commitment to a health promoting, social model of health which:

- Addresses the broader determinants of health, recognising that political, social, economic and environmental factors are critical;
- Bases activities on the best available data and evidence;
- Encourages public participation by individuals and communities;
- Explicitly considers difference in gender and culture;
- Acts to reduce inequity and promote social justice;
- Fosters intersectoral collaboration and partnerships;
- Empowers individuals and communities, and
- Focuses on enhancing health, not just preventing illness.

ISEPICH will undertake a capacity building process with member organisations to identify opportunities to work both individually and in collaboration with other organisations to reduce health inequality.

## **Achieving the vision: Capacity Building Plan**

## Addressing Health Inequality

Goal	Objective	Strategies/Interventions	Estimated Impact
<p>To reduce health inequalities in the ISEPICH catchment</p>	<p>To build the capacity of ISEPICH member agencies to address health inequality.</p> <p>To develop and implement a collaborative approach to reducing health inequalities (health inequalities framework) in ISEPICH.</p>	<p>Develop a discussion paper, including a literature review. Identify the dimensions of the issue within the ISEPICH catchment, including limitations of data collected by state and federal governments.</p> <p>Document and analyse data in relation to those with the worst health status in the ISEPICH catchment.</p> <p>Identify and document the risk factors which lead to poor health outcomes within certain groups.</p> <p>Consult with member agencies to identify current understanding of and approaches to reducing health inequality.</p> <p>Facilitate dialogue and collaboration between ISEPICH members and other relevant stakeholders to reduce health inequality.</p> <p>Identify interventions that have been proven to be effective in reducing health inequality.</p>	<p>Increased knowledge by member organisations about the determinants of health and the risk factors which can contribute to health inequality.</p> <p>ISEPICH members have policies and programs that effectively reduce health inequality.</p>

## Review of Partnership Structures and Processes

Goal	Objective	Strategies/Interventions	Estimated Impact
<p>To identify the most effective structure to provide leadership and strategic direction across the full range of functions which require a partnership approach in the health, community and primary care sectors in the Inner South East.</p>	<p>To review ISEPICH's structure and processes including:</p> <ul style="list-style-type: none"> <li>▪ membership criteria and categories</li> <li>▪ existing committee and working groups structures/processes</li> <li>▪ reporting, communication and decision making processes</li> <li>▪ memorandum of understanding and good governance guide.</li> </ul>	<p>To consult with key groups to ensure that changes made to ISEPICH's structure, processes and operations compliments other existing (and proposed) partnership structures including:</p> <ul style="list-style-type: none"> <li>▪ HARP/CDM Programs,</li> <li>▪ Inner South East Area Health Council,</li> <li>▪ Bayside Health Primary Care and Population Health Advisory Committee,</li> <li>▪ Inner South Mental Health Alliance,</li> <li>▪ The Inner South East District Planning Group</li> <li>▪ Area Based Planning Network (Care in Your Community)</li> </ul> <p>To consult with ISEPICH member agencies to determine options for reform (including whether representation on the Executive Committee should be from a sector perspective, rather than the current individual agency perspective)</p> <p>To review terms of reference and communication/reporting processes for working groups and other forums/networks.</p>	<p>Active participation by relevant stakeholders in ISEPICH's committees and processes.</p> <p>Effective communication and decision making processes within ISEPICH.</p> <p>Effective communication processes with other relevant partnership structures within the Inner South East.</p>

## List of PCP member agencies/organisations and explanation of membership types

Agency name	Type of membership	Deliverable/s involved in
Access Care Southern	Full	Service Coordination
Access Health	Full	Integrated Health Promotion
Arthritis Foundation of Victoria	Full	Integrated Health Promotion
Australian-Polish Community Services	Full	Integrated Health Promotion/ Service Coordination
Bayside Health	Full	Integrated Health Promotion/ Service Coordination
Bentleigh Bayside Community Health Service	Full	Integrated Health Promotion/ Service Coordination
Bethlehem Hospital	Full	Service Coordination
Better Hearing Australia	Full	Integrated Health Promotion (CALD Strategy)
Caulfield South Community House	Full	Integrated Health Promotion
Centre Against Sexual Assault	Full	Integrated Health Promotion/ Service Coordination
Christ Church Mission	Full	Integrated Health Promotion
City of Glen Eira	Full	Service Coordination
City of Port Phillip	Full	Integrated Health Promotion/ Service Coordination
City of Stonnington	Full	Integrated Health Promotion/ Service Coordination
Connections	Full	Integrated Health Promotion (CALD Strategy)
Do Care	Full	Service Coordination
Froniditha Care Inc	Full	Service Coordination
Gawith Villa	Full	Integrated Health Promotion/
Inner South Community Health Service	Full	Integrated Health Promotion/ Service Coordination
HomeGround Services	Full	Integrated Health Promotion/ Service Coordination
South City GP Services	Full	Integrated Health Promotion/ Service Coordination
International Diabetes Institute	Full	Integrated Health Promotion
Jewish Care	Full	Integrated Health Promotion/ Service Coordination
John Macrae Centre	Full	Service Coordination
Kosher Meals on Wheels Association	Full	Integrated Health Promotion
Marillac House	Full	Integrated Health Promotion/ Service Coordination
MECWA Community Care	Full	Service Coordination

MOIRA	Full	Integrated Health Promotion
Monash Division of General Practice	Full	Integrated Health Promotion/ Service Coordination
Napier Street Aged Care Services	Full	Integrated Health Promotion
Polish Community Council	Full	Integrated Health Promotion (CALD Strategy)
Prahran Mission	Full	Integrated Health Promotion
Richmond Fellowship	Full	Integrated Health Promotion
Royal District Nursing Service – Caulfield	Full	Service Coordination
Sacred Heart Mission	Full	Integrated Health Promotion
Mental Illness Fellowship of Victoria	Full	Integrated Health Promotion
School Focused Youth Service	Full	Integrated Health Promotion
South Central Region Migrant Resource Centre	Full	Integrated Health Promotion/ Service Coordination
South Port Day Links	Full	Integrated Health Promotion/ Service Coordination
St Kilda Drop In	Full	Integrated Health Promotion
Port Phillip Community Group	Full	Integrated Health Promotion
The Salvation Army Bridge Program	Full	Integrated Health Promotion (CALD Strategy)
Taskforce	Full	Integrated Health Promotion
Vision Australia	Full	Integrated Health Promotion/ Service Coordination
The Windana Society	Full	Service Coordination
Women's Health in the South East	Full	Integrated Health Promotion

# Service Coordination Strategy

## Introduction

The aim of ISEPICH's Service Coordination Strategy is to improve access, responsiveness and integration of the primary care service system to ensure that services are provided in a seamless, co-ordinated way and that consumer and carer outcomes are enhanced. The Strategy is based on multiple points of entry into the service system, so that services become "functionally integrated"<sup>3</sup> while retaining their organisational autonomy and agreeing to a common approach to the following functions:

- Initial Contact
- Initial Needs identification
- Assessment
- Referral
- Care Planning
- Feedback loop to referring provider

The strategy is informed by two key principles:

- *Consumer focus* – the Service Coordination Strategy places consumers at the centre of service delivery, to ensure that they have access to the services they need, opportunities for early intervention, health promotion and improved health, and
- *Respect for individual agencies* – that practices and protocols take into account the purpose, philosophy and obligations of individual ISEPICH member agencies.

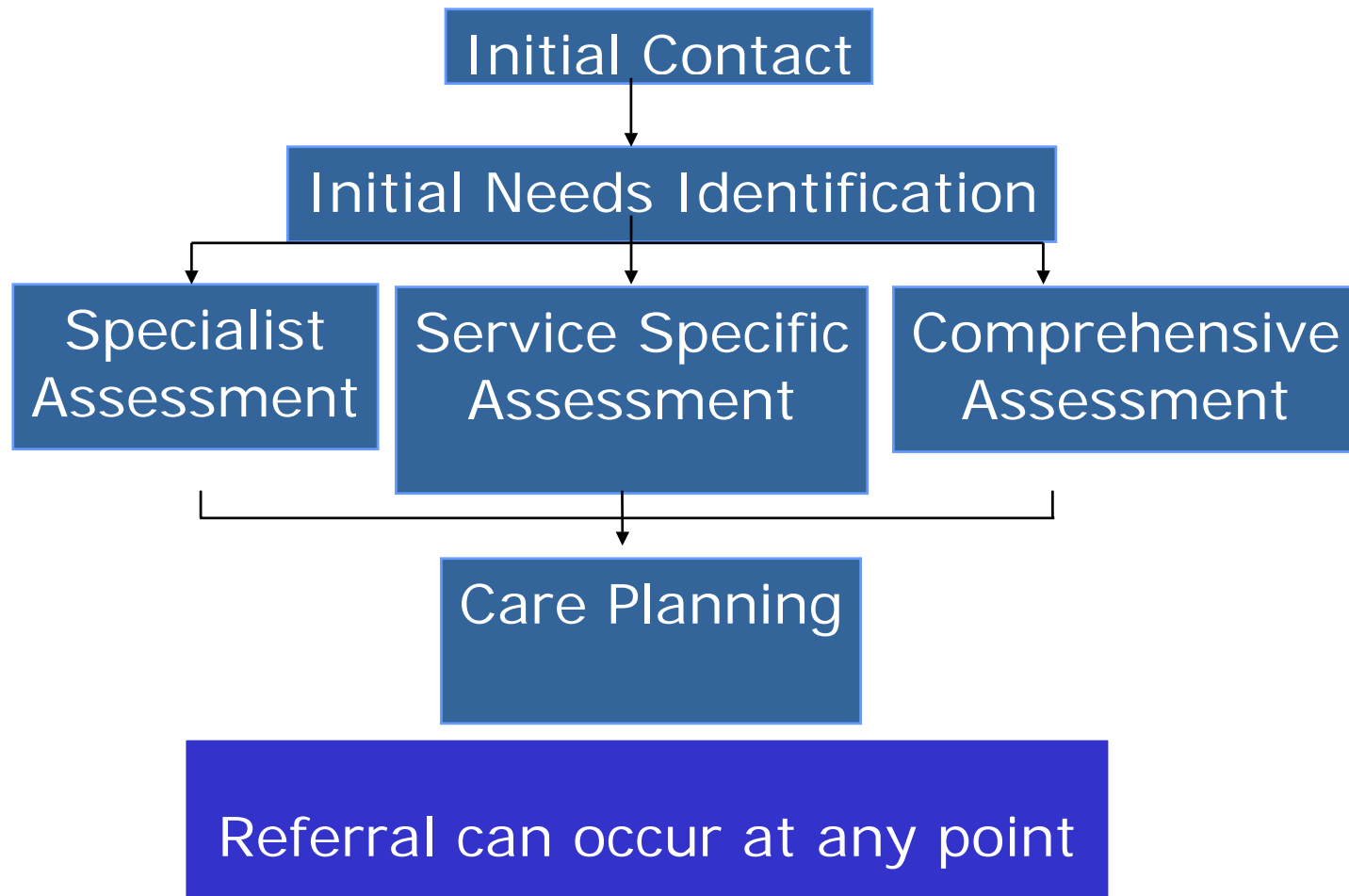
From 2007 ISEPICH will implement the Statewide Service Coordination Practice Manual and will work closely with the other three PCPs in the Southern Region to ensure there is consistency of practice across the region. Other key elements of ISEPICH'S Service Coordination Strategy for 2007- 2009 include:

- Incorporating a focus on chronic disease management and also ensuring that service coordination and health promotion are integrated
- Expanding the reach of Service Coordination to other sectors, including alcohol and other drugs, disability, housing and mental health
- Continuing the implementation of electronic referral.

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<sup>3</sup>Functional integration means that agencies remain independent of each other as entities but work in a cohesive and coordinated way to ensure that consumers experience a seamless and integrated response, ensuring consumers get access to the services they need as quickly as possible without unnecessary barriers or duplication. *Better Access to Services – A Policy and Operational Framework*, p.32, DHS, June 2001.

# Elements of Service Coordination



<b>Goal</b>	<b>Objective</b>	<b>Strategies/Interventions</b>	<b>Estimated Impact</b>
<p>1. Implement the Better Access to Services (BATS) framework by progressing common practices, processes, protocols and systems for initial contact, initial needs identification, referral, assessment and care planning by member organisations.</p>	<p>To implement the Victorian Service Coordination Practice Manual and subsequent versions of the Service Coordination Tool Templates.</p> <p>To support the widespread implementation of the agreed practices, processes and protocols as outlined in the Manual by ISEPICH member agencies.</p> <p>To improve access, initial needs identification and referral (with a focus on people from diverse backgrounds and those who face barriers in accessing services, including CALD community members)</p>	<p>To consult with member agencies to ascertain the extent to which the BATS framework has been implemented and identify what support is required to comprehensively implement the framework.</p> <p>To provide support and resources to assist in the development of individual agency policy and practice to implement the BATS framework.</p> <p>Build the capacity of member agencies to provide the necessary support and training of staff in relation to service coordination (including orientation for new staff).</p> <p>Provide support to prioritised general practices to improve knowledge of primary care services, health promotion opportunities and quality of referrals including use of the Statewide Referral Form</p>	<p>That the BATS framework will be comprehensively implemented within relevant member agencies by late 2007.</p> <p>An expanded number of agencies, from other sectors will have implemented relevant aspects of the BATS framework (these sectors include, Disability, Housing, Alcohol and other drugs, Mental Health).</p>
<b>Goal</b>	<b>Objective</b>	<b>Strategies/Interventions</b>	<b>Estimated Impact</b>
<p>2. To improve the quality and consistency of referral to primary care agencies</p>	<p>Improve communication about clients (especially those with chronic disease and complex needs) with general practice, leading to more active GP participation with other service providers involved in the client's care.</p> <p>To improve GPs knowledge of primary care services and opportunities for health promotion.</p>	<p>To visit priority GP practices to provide information and support regarding ISEPICH's service coordination strategy.</p> <p>Promote awareness of ISEPICH's service coordination strategy and agreed approaches for referral and feedback (including ongoing feedback in relation to clients with a chronic illness).</p> <p>Develop targeted strategies and resources for GPs to improve their knowledge of services/health promotion opportunities</p> <p>Provide individual support to GPs/Practice staff on how to do referral using the SRF.</p>	<p>Enhanced understanding of and compliance with ISEPICH's agreed referral and feedback processes.</p> <p>Improved continuity of care for people with chronic illness.</p>

Goal	Objective	Strategies/Interventions	Estimated Impact
3. That people have access to appropriate primary and community care services and supports on discharge.	To work collaboratively with Bayside Health to improve the continuity of care from hospital to home.	Provide support to relevant hospital departments to implement relevant aspects of the BATS framework. To increase the awareness of and usage of relevant tools and resources by Bayside Health (including e-referral and the HSD/Infoxchange Service Seeker).	Improved continuity of care such that the interface between the primary care and acute sectors will be seamless and that the notion of 'discharge' from the acute sector will become obsolete. Key staff in relevant departments will: <ul style="list-style-type: none"> <li>▪ Have improved knowledge of the full range of services and supports available in the primary care sector</li> <li>▪ Make optimum use of available resources such as the SSD, ISEPICH Website etc</li> <li>▪ Implement relevant elements of the BATS framework, including using the SCTT's for referral</li> </ul>
Goal	Objective	Strategies/Interventions	Estimated Impact
4. Change management support for implementation of e-referral	To implement the Infoxchange s2s e-referral system within relevant ISEPICH member agencies, including Bayside Health.  To consult with GPs and Divisions to identify the most appropriate approach to implementation of e-referral within the GP sector. (A key consideration will be to ensure that the systems functionality, implementation requirements and financial cost makes it viable for individual GPs to implement)	To demonstrate the s2s system to a focus group of GPs and divisional staff To identify any barriers and constraints that need to be addressed to ensure To hold a privacy forum in early 2007 to ensure that agencies are aware of their responsibilities in regard to the collection, storage and transmission of personal information within an e-referral context. To liaise with the InfoXchange in addressing relevant issues and providing the necessary support to enable GPs to implement the s2s system PCP and Divisional staff will work with key Community Health Service personnel to develop a strategic approach to the engagement of individual GPs.	Widespread implementation of electronic referral between ISEPICH member agencies.  Implementation of electronic referral within general practice on an incremental basis.
Goal	Objective	Strategies/Interventions	Estimated Impact
5. Improved amount and	To support agencies to ensure that	Support member agencies to improve	That all member agencies have

<p>accuracy of information to support referral through the Human Services Directory and other service directories.</p> <p>To increase the number of agencies using the full range of information resources including the HSD/Infoxchange Service Seeker, Go For Your Life, ISEPICH and other websites.</p>	<p>service information is comprehensive, accurate and up to date within the HSD and other relevant electronic service directories.</p> <p>To ensure that relevant staff have a broad knowledge of the range of available resources and are competent in accessing these.</p>	<p>their processes for the maintenance of their service and health promotion information on relevant electronic service directories.</p> <p>To ensure that information about physical activity programs within the ISEPICH catchment are recorded on the Go For Your Life Website and that this information is promoted specifically to general practice as well as other service providers.</p> <p>Provision of support and training, including orientation for new staff.</p>	<p>access to comprehensive and up to date service and health promotion information.</p> <p>Increased referrals from general practice and other providers for physical activity programs.</p> <p>Consumers will have access to relevant health information, health promotion programs and services available.</p>
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# Integrated Chronic Disease Management

Goal	Objective	Strategy	Planned Impact
1. Completion of a mapping of self-management interventions (provided by agencies within the catchment). Facilitate planning processes to develop self-management interventions within member agencies that respond to gaps identified in the mapping process.	<p>To map self-management interventions provided/supported by agencies within the ISEPICH catchment</p> <p>To identify gaps in self-management interventions in the catchment</p> <p>To develop self-management interventions to address gaps</p>	<p>Survey of member agencies and other relevant local organisations, to be completed by April 2007 by PCP staff, Service Coordination Advisory Group (SCIAG) to oversee</p> <p>SCIAG to host forum on results of the above in May 2007. Identify gaps and range of chronic diseases to be addressed.</p> <p>Workshop/s to develop agreed plan in June – December 2007 Implementation 2008 Evaluate and review 2009</p>	<p>Resource listing existing interventions and support groups (to be available on web) by June 2007</p> <p>Improved self-management options for people with a broader range of chronic diseases (Evaluate by survey in 2009)</p>
2. Facilitation of a process for agencies to define their roles and responsibilities, especially acute and community health services, in relation to providing self-management interventions for people with chronic disease.	To develop a protocol outlining roles and responsibilities of member agencies in providing self-management options for people with chronic disease	<p>Developed as part of plan above Implemented 2008 Evaluate and review 2009 SCIAG to oversee</p>	Positive experience of referral and coordination between agencies for people with chronic disease (Evaluate by survey of consumers in 2009)
3. Successful implementation of the Better Access to Services (BATS) framework by progressing common practices, processes, protocols and systems for initial contact, initial needs identification, referral, assessment and care planning by member agencies, particularly as it relates to people with chronic disease.	To ensure existing Service Coordination practices, processes and protocols for initial contact, initial needs identification and referral are relevant to people with chronic disease, and carers	<p>SCIAG to be responsible for review of existing practices, processes and protocols for initial contact, initial needs identification and referral to ensure they are relevant to people with chronic disease by July 2007.</p> <p>Information and education to be provided to member agencies as required in 2007-08 Evaluate and review 2008-09</p>	People with chronic disease have access to the full range of services, supports and self management programs they require.
4. Developed and defined local agreements and systems to	To develop a protocol for the identification and referral of clients	SCIAG to be responsible for protocol development in 2006-07	People with chronic disease have access to effective care planning and

<b>Goal</b>	<b>Objective</b>	<b>Strategy</b>	<b>Planned Impact</b>
identify clients with chronic disease who require comprehensive assessment, by working with PCP member agencies, particularly GPs.	with chronic disease who require comprehensive assessment.	Implementation 2007-08 with information and education to member agencies as required Evaluate and review 2008-09	coordination of care (records audit?)
5. Developed and defined local agreements and systems to identify clients with chronic disease who require cross-disciplinary/multi-agency (including GP) care planning, by working with PCP member agencies, particularly GPs.	To develop agreements and systems for identification of people with chronic disease who require care planning as part of the broader development of practices, processes and protocols for care planning in ISEPICH	SCIAG to be responsible for development in 2007-08 Implementation 2008-09	Effective coordination and referral between agencies in care planning for people with chronic disease.
6. Developed and defined local agreements and systems around initiating and coordinating care planning for people with chronic disease by working with PCP member agencies, particularly GPs.	To develop agreements and systems for initiating and coordinating care planning of people with chronic disease as part of the broader development of practices, processes and protocols for care planning in ISEPICH. To ensure person centred care planning To ensure support and participation of carers as needed	SCIAG to be responsible for development in 2007-08  Implementation 2008-09  Identify appropriate tools and resources  Undertake capacity building/workforce development	Effective care planning for people with chronic disease. Participation of people with chronic disease (and carers where appropriate) in their care planning Increased sense of self-efficacy Improved self-management of disease and quality of life for people with chronic disease and carers (survey consumers & carers)
7. Strengthened approaches to address disadvantage and health equality in Integrated Health Promotion initiatives, including barriers to participation such as chronic disease.	ISEPICH Health Inequality framework to ensure that health promotion addresses all stages of the chronic disease continuum. HI framework to ensure that health promotion is inclusive of people with chronic disease HI framework to ensure health promotion addresses barriers to community participation experienced by people with chronic disease.	HI Framework to be developed in 2007-08, to address all areas of PCP work (Partnerships, IHP, SC, ICDM). To be implemented 2007-08 Evaluate and review 2008-09. ISEPICH Executive to oversee.	Improved health equality for people with chronic disease in ISEPICH (eg effective self-management, quality of life, participation in health promotion activities and broader community).  HI framework to include evaluation measures to ensure impacts can be assessed.

# Integrated Health Promotion

## 1. Health promotion vision

ISEPICH's vision is of a community where health is valued as a basic resource for living, different sectors share the responsibility for creating conditions that support good health, and improved health outcomes are shared equitably.

A key component of ISEPICH's vision for 2006-09 is to strengthen the partnership and build capacity for integrated health promotion planning, implementation and evaluation. ISEPICH will also be working to strengthen capacity in relation to health inequalities. The proposed intervention is a "Health Inequalities/Equity and Inclusion" framework, with associated resources and workshops. This will build on the existing work of member agencies in addressing health inequalities, and also on previous ISEPICH initiatives including the Integrated Cultural and Linguistic Diversity Strategy,<sup>4</sup> "Not the Rich List"<sup>5</sup> and the Rooming House project.

Several other issues have also been identified as particularly important for health promotion in 2006-09. One is the ongoing need to re-orient services towards the promotion of health as well as the treatment of illness. This will require support from senior and middle management in member agencies, and also the support of government and funding bodies.

Another issue is the potential for a "whole of community" approach to health promotion. Thus the focus of health promotion would not only be on working with disadvantaged groups, but also on looking at the responsibilities of middle class and wealthier people, and building their capacity to contribute to community wellbeing. This should not be limited to "charitable" approaches, but aim for sustainable social and cultural change. For example, this could include practical measures such as employment opportunities for disadvantaged groups, and support for more affordable housing, and could also include cultural measures such as community festivals and forums to bring the community together.

Another issue is the need to integrate health promotion action. The three ISEPICH priority issues for 2006-09 are mental wellbeing, physical activity and nutrition & food security. These issues have underlying social determinants in common, which may be most effectively addressed in an integrated way, as recommended by the World Health Organisation.<sup>6</sup> We can seek opportunities for integrated health promotion interventions that address all priority issues, and their underlying determinants, simultaneously. For example, this could be done through settings based approaches. Member agencies have an established tradition of working collaboratively on settings based health promotion and can build on this tradition.

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<sup>4</sup> Available at [www.isepich.org](http://www.isepich.org) under Cultural and Linguistic Diversity

<sup>5</sup> Available at [www.isepich.org](http://www.isepich.org) under Integrated Health Promotion – Health Promotion resources – general.

<sup>6</sup> See for example the World Health Organisation 'CINDI' strategy at [http://www.euro.who.int/CINDI/20020319\\_2](http://www.euro.who.int/CINDI/20020319_2)

## 2. Priority setting and problem definition

### Community profile

The ISEPICH catchment is a growing population, estimated at 300,000 people in the 2001 census, and characterised by diversity:

- A population that includes the very rich and the very poor,
- An extreme range of housing types, including significant numbers of people who live in supported residential services, rooming houses and community housing
- A relatively high proportion of people over 75 years of age in some areas
- A projected increase in the number of people aged 50-70 years
- Significant smaller populations with co-morbidities and high needs
- Pockets of youthful populations and ageing populations
- The highest proportion of people over 65 years in Victoria who live alone
- Culturally and linguistically diverse communities with high levels of people born overseas including a large Jewish community, and
- Areas that have the highest concentration of gay and lesbian people in Victoria.

### Health Issues

The Victorian Burden of Disease Study and the 2005 Population Health Survey provide a comprehensive review of health and illness at local and regional level in Victoria. Chronic diseases or conditions that cause the greatest burden to the ISEPICH population are heart disease, cancer, mental health, injuries (especially falls) and drug and alcohol abuse.

Significant issues for sections of ISEPICH's catchment population include dementia, diabetes and infectious diseases, including HIV/AIDS. Risk factors influencing the health of the population include social isolation, violence, physical inactivity, poor nutrition, alcohol harm, illicit drug use, and unsafe sex.

### Health Promotion Planning Forum

ISEPICH held an Integrated Health Promotion Planning Forum at Ashley Ricketson Centre on 23 May 2006. The purpose of the forum was to:

- Ensure member agencies had a common understanding of basic purpose and structure of ISEPICH
- Provide member agencies with an overview of the health and socio-demographic status of the catchment population
- Provide member agencies with an overview of the health promotion priorities and planning process of the three local governments and three community health services in the catchment.
- Gain agreement among member agencies on the health promotion priorities to be addressed in an integrated way across the catchment in 2006-09.

Forty-two (42) people attended the forum, including 36 representatives of 27 member agencies and six community representatives.

The program included:

- An introduction providing an overview of the purpose and structure of ISEPICH
- A series of presentations about the socio-demographic and health issues of the catchment population
- A series of presentations on the health promotion priorities and community consultation outcomes of key member agencies and
- Facilitated large and small group discussions about the ISEPICH health promotion priorities for 2006-09 and the broad goals and objectives to be set for 2006-09.

Copies of the PowerPoint presentations given on the day are available on the ISEPICH website at [www.isepich.org](http://www.isepich.org) under Integrated Health Promotion

### **Criteria for setting ISEPICH health promotion priorities**

- Significance of the impact and scale of the issue
- Degree of health inequality
- Amenability to change
- Strategic opportunity
- Capacity
- Relevance to ISEPICH members

Identifying and prioritising health promotion issues to be addressed by ISEPICH in 2006-09 were undertaken in three stages.

#### Stage 1

Forum participants had the opportunity during a large group facilitated discussion to nominate the health promotion issues that they or their organisations thought should be a priority for ISEPICH in 2006-09. This process generated considerable discussion with suggested priorities ranging from specific diseases (cancer, cardiovascular disease, diabetes etc) to the broader determinants of health (poverty, education, employment etc). After further discussion it was agreed that the issues raised could be appropriately allocated to the priority areas of; physical activity promotion, mental health promotion, access & equity, and food & nutrition.

#### Stage 2

Each forum participant was asked to identify his or her top three priorities from the options of physical activity promotion, mental health promotion, access & equity, and food & nutrition using coloured sticky dots. The 'score' for each option was then totalled to provide an indication of the relative priority given to each of the issues. The outcome of this process was that mental health promotion ('score' of 67) and access & equity (60) were identified as clear priorities with food & nutrition (35) and physical activity (34) considered less important.

Following this process there was further discussion as to whether access & equity (or health inequalities more broadly) should be considered as a:

- stand-alone health promotion priority
- an integral part and guiding principle of all health promotion work or
- a priority for ISEPICH generally including through service coordination work

At the conclusion of this discussion it was agreed that physical activity promotion, mental health promotion, and food & nutrition would be the ISEPICH health promotion priorities and that access & equity/health inequalities would be considered a whole-of-ISEPICH capacity building priority for 2006-09. It was agreed that access & equity/health inequalities would be drawn to the attention of the ISEPICH

Executive and Executive members would be asked to oversee the development of a strategic approach to building the capacity of member organisations to address the health needs of the most disadvantaged members of the catchment population.

### Stage 3

Forum participants were asked to join one of three facilitated small groups based around the agreed priority issues of physical activity promotion, mental health promotion, and food & nutrition. The purpose of the small group discussions was to begin to identify, for each priority issue:

- Key outcomes/goals to be achieved by 2009
- Key known or potential interventions/activities/strategies to be implemented or undertaken
- Barriers to undertaking partnership activities
- Support required to overcome barriers

Goals for each area were identified, and are included below. A number of possible objectives, barriers, facilitators and other relevant issues were also identified, which will be considered in further planning processes, as discussed below.

### Evaluation

Eleven Evaluation and Feedback forms were completed and returned by Forum participants. This represents about 25% of participants. In general the feedback and comments were positive with most respondents indicating that the quality of the dialogue/discussion was high and the input from presenters and opportunities to contribute were excellent. Although most respondents felt that the purpose of the Forum was achieved, there was some concern that we tried to do too much in one session and that the previous and current work of the ISEPICH Action Groups was not used sufficiently to inform future plans. It was generally acknowledged that the Forum was a good first step in developing an Integrated Health Promotion Plan for 2006-09 but a lot of work will need to be done to identify relevant and achievable strategies that will actively engage ISEPICH member agencies in integrated health promotion.

Following the planning day, the ISEPICH Health Promotion Working Group agreed to work on improving catchment health promotion planning in 2006-07, utilising the National Public Health Partnership planning framework as a resource.<sup>7</sup> Goals and objectives for ISEPICH Health Promotion 2006-09 are set out below. These will be progressively updated as the catchment planning process continues.

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<sup>7</sup> National Public Health Partnership (NPHP) *op cit* 2006.

## Mental wellbeing

### Goal:

To improve mental wellbeing in the ISEPICH catchment.

### Objectives:

1. By September 2007, to develop a catchment mental wellbeing promotion plan for ISEPICH (This IHPP will be updated to reflect the plan at that time).
2. To implement and evaluate the mental wellbeing plan in 2007 - 2009.
3. To support ongoing partnership initiatives aiming to promote mental wellbeing in the ISEPICH catchment, including:
  - Welfare to Work research and advocacy project
  - Advocacy to increase affordable housing in the catchment
  - Agreed approach to Health Promotion in Rooming Houses in the catchment
  - Building the capacity of ISEPICH agencies to provide inclusive health promotion and services.(The ongoing objectives will also contribute to the development of the health inequalities framework)

### Rationale

In the ISEPICH catchment, mental disorders were responsible for 16.4% of the burden of disease (disability adjusted life years) in the City of Port Phillip, 14.5% of the burden of disease in Stonnington and 11.8% in Glen Eira.<sup>8</sup> This makes mental disorders the third highest cause in burden of disease in Port Phillip and Stonnington, and fourth highest in Glen Eira. In addition, neurological and sense disorders (which include Alzheimer's and other forms of dementia) were responsible for 14.3% of the burden of disease in Glen Eira, 13.3% in Stonnington and 12.5% in Port Phillip, while intentional injury (which includes violence, self harm and suicide) accounts for 2.7% in Port Phillip, 2.2% in Stonnington and 1.8% in Glen Eira.

Mental health is one of the seven national health priority areas for Australia. Self-reported long-term mental and behavioural health problems in Australia increased from 5.9 per cent to 10.7 per cent between 1995 and 2004-5.<sup>9</sup> Self-reported high levels of distress also increased from 2.2 to 3.3 per cent.<sup>10</sup> Nationally, it is estimated that about 25% of the population experiences some kind of mental health problem annually. People with mental health conditions are also at risk of physical illness related to lifestyle factors, such as smoking, drug and alcohol use and poor nutrition.<sup>11</sup>

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<sup>8</sup> Information on Burden of Disease is derived from the Victorian Department of Human Services Burden of Disease database at <http://www.health.vic.gov.au/healthstatus/> (accessed November 2006) unless otherwise specified.

<sup>9</sup> Australian Institute of Health and Welfare (AIHW) *Australia's Health 2004* Canberra, AIHW 2004 p 43.

<sup>10</sup> *Ibid* p 98

<sup>11</sup> *Ibid* p 102

Promoting mental health and wellbeing is one of the seven health promotion priorities for Victoria for 2007-12. VicHealth has developed a framework for the promotion of mental health that identifies on three key determinants, social inclusion, freedom from discrimination and violence, and access to economic resources.<sup>12</sup>

The relatively high rate of mental disorders in Port Phillip probably reflects in part the fact that there are a significant number of mental health and support services in the area, but also reflects a relatively high concentration of disadvantaged groups in parts of Port Phillip, including what has been described as:

*an intricate and complex relationship between various layers of disadvantage – mental illness, (street) sex work, poverty, homelessness, social stigma and social isolation and marginalisation.*

(Borderlands Cooperative Inc 'Vulnerable Groups Project report' Gambler's Help Southern, December 2002)

More information about these factors may be found in the ISEPICH Publication *Not the Rich List*.<sup>13</sup>

Experience in ISEPICH 2004-06 has shown that while there is widespread support for the promotion of mental wellbeing and social connectedness, there is not clear agreement on the best approach. The health promotion planning forum in May 2006 identified mental wellbeing as a key priority for 2006-09. At the same time, mental health services in ISEPICH, most of which are represented on the Inner South Mental Health Alliance (ISMHA), are interested in incorporating mental health promotion in their plan. Broadly speaking, however, ISMHA members are focused on promoting the wellbeing of existing clients, a significant proportion of whom have serious mental illness such as schizophrenia, while the ISEPICH Health Promotion Working Group is focused on the promotion of mental wellbeing and the prevention of mental disorders in the population. There is some overlap between the target populations, particularly in the case of people with depression, and the underlying determinants to be addressed, such as secure housing, social connectedness and freedom from violence, discrimination and stigma, are similar. Nevertheless there are significant practical problems in balancing the needs of different population groups (people with serious mental illness, people with or at risk of common mental disorders, and the community in general), and agreeing on how different agencies can effectively work together and how resources should be distributed.

In common with all other health promotion priority areas, the first objective of ISEPICH in mental wellbeing promotion in 2006-07 will be to improve catchment planning. The first step will be to agree on a common definition of mental wellbeing promotion in ISEPICH, and then to develop a more detailed catchment plan defining key objectives, population groups and strategies, and identifying the different roles and responsibilities of partners. At the same time, ISEPICH will continue to support ongoing partnership interventions.

## **Physical activity**

### **Goal:**

To improve the health of the local community through increased physical activity levels.

### **Objectives:**

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<sup>12</sup> Available at [http://www.vichealth.vic.gov.au/Content.aspx?topicID=72#cs\\_124](http://www.vichealth.vic.gov.au/Content.aspx?topicID=72#cs_124) (accessed 5 December 2006).

<sup>13</sup> Available at <http://www.portphilip.vic.gov.au/attachments/o10364.pdf> (accessed 29 November 2006).

1. By April 2007, to develop a catchment physical activity promotion plan for ISEPICH (This IHPP will be updated to reflect the plan at that time).
2. To implement and evaluate the physical activity promotion plan in 2007-09.
3. To support ongoing partnership initiatives aiming to increase physical activity within the ISEPICH catchment, including:
  - a. Healthy and Active Living for Seniors funded project
  - b. Strength Training Network
  - c. Falls Prevention Community Network (including funded Falls Prevention project in ISEPICH and Kingston Bayside PCP)

#### Rationale

The Victorian Population Health Survey estimates that just under 40% of adults in the Southern Metropolitan Region are not sufficiently active for health benefit, with about 8% being inactive or sedentary and about 30% being insufficiently active. (Figures at Local Government area or PCP catchment area level are not available).<sup>14</sup> These estimates of physical inactivity are somewhat lower than broader population estimates. For example Garrard et al<sup>15</sup> state that about half of the Australian population are insufficiently active. It is possible that the estimates for the Southern Metropolitan Region overestimate physical activity in the region.

Women, older people and those with lower education levels in the region had lower physical activity levels than other population groups, although not all of these differences were statistically significant.

The burden of disease attributed to physical inactivity in the region is just under six per cent for males and about eight per cent for females. Moreover, about four per cent of the burden of disease for males and females is attributed to obesity, about four per cent for males and just over five per cent for females to high cholesterol levels and about six per cent for males and seven per cent for females to high blood pressure. Increased physical activity can also contribute to a reduction in these risk factors.

Disease conditions for which increased physical activity levels can be particularly beneficial include cardiovascular disease, musculo-skeletal conditions and diabetes mellitus. In Glen Eira, cardiovascular disease is responsible for 25.7% of burden of disease, making it the highest contributor to the burden of disease, musculo-skeletal conditions for 3.8% (sixth highest), and diabetes 3.0% (eighth). In Port Phillip, cardiovascular disease accounts for 22.4% (highest), musculo-skeletal 2.9% (ninth) and diabetes 2.7% (eleventh), while in Stonnington cardiovascular disease accounts for 25.4% (highest), musculo-skeletal 3.7% (sixth) and diabetes 2.5% (eleventh). In

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<sup>14</sup> Information on physical activity levels is drawn from the Department of Human Services Victorian Population Health Survey database at <http://www.health.vic.gov.au/healthstatus/> (accessed November 2006) unless otherwise specified.

<sup>15</sup> J Garrard, B Lewis, H Keleher, N Tunny, L Burke, S Harper & R Round, *Planning for healthy communities: reducing the risk of cardiovascular disease and type 2 diabetes through healthier environments and lifestyles*, Victorian Government Department of Human Services, Melbourne 2004. Available at [http://www.health.vic.gov.au/healthpromotion/downloads/healthy\\_communities.pdf](http://www.health.vic.gov.au/healthpromotion/downloads/healthy_communities.pdf)

addition, research suggests that increased physical activity levels may be protective against mental disorders (particularly if undertaken in group settings), and certain cancers, particularly colon cancer.<sup>16</sup>

Barriers and facilitators to physical activity include individual, social, cultural and environmental factors. Disadvantaged groups and people with lower education levels are at particular risk of physical inactivity. In order to increase physical activity levels, health promotion needs to address these factors. Garrard et al state that individual and group interventions, including those in health care settings, can increase physical activity levels in the short term but are not likely to lead to long term improvement unless linked to broader social support and community participation and ownership. Information and social marketing are useful for raising awareness but do not usually lead to sustained improvements unless combined with community programs. These strategies also need to be carefully targeted if they are to reach high risk and disadvantaged groups. Multi-strategy community wide interventions have been found to be effective. Community action, policy and environmental change is important for creating environments (social, cultural and built) that support physical activity and in contributing to long-term sustainable change, such as increased rates of regular daily physical activity.

The ISEPICH Physical Activity Action Group will develop a catchment physical activity promotion plan during November 2006-April, using the NPHP planning framework and evidence based resources, such as Garrard et al and *Getting Australia Active*. The group will also continue to support existing physical activity interventions as above.

## **Nutrition and Food Security**

### **Goal:**

To increase capacity within the ISEPICH catchment to address nutrition and food security.

### **Objectives:**

1. By April 2007, to develop a nutrition and food security promotion plan for ISEPICH. (This IHPP will be updated to reflect the plan at that time).
2. To implement the plan in 2007-09.
3. To support ongoing partnership initiatives aiming to promote nutrition and food security in the ISEPICH catchment.

### **Rationale**

The Victorian Population Health Survey 2005 indicated that only 10.9% of adult males and 12.3% of adult females in the Southern Metropolitan region ate the recommended five serves of vegetables per day, and only 39.9% of males and 53.5% of females ate the recommended two serves of fruit per day. Younger age groups were generally less likely to eat the recommended serves of fruit and vegetables daily than older age groups.

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<sup>16</sup> FC Bull, AE Bauman, B Bellew & W Brown *Getting Australia Active II: An update of evidence on physical activity for health* Melbourne, Australia. National Public Health Partnership (NPHP) August 2004 available at [http://www.nphp.gov.au/publications/documents/gaa\\_2\\_section\\_1\\_ver1](http://www.nphp.gov.au/publications/documents/gaa_2_section_1_ver1). (accessed November 2006)

The survey also indicated that 2.6% of males and 4.75 of females were classified as underweight (BMI less than 18.5), 39.7% of males and 24.3% of females were classified as overweight (BMI 25 – 30), and 12.8% of males and 11.2% of females were classified as obese (BMI greater than 30). In common with many other countries the rate of overweight and obesity in Australia is increasing and there is particular concern about the increasing rate in children.

Diseases conditions for which improved nutrition is likely to be beneficial include cardiovascular disease, diabetes, and cancers, similar to physical activity. In addition there are several ambulatory sensitive care conditions that have a significant nutritional component and are responsible for a significant proportion of admitted bed days in the catchment, particularly dehydration and gastro-enteritis, dental conditions, and iron deficiency anaemia.

As with physical activity, factors affecting nutritional status and eating behaviour include individual, social, cultural and environmental factors, and disadvantaged groups are particularly at risk. One important influence on eating behaviour is advertising of energy dense, nutrient poor (ENDP) food. Australia's rate of ENDP food advertising, particularly to children, has been one of the highest in the world in recent years, and remains high.<sup>17</sup> As well as being widely promoted, EDNP food is often cheaper and more readily available than more nutritious food, which is especially significant for disadvantaged groups.

"Fad diets", which promise a quick fix to overweight, are also widely promoted. Fad dieting appears to be common in all age groups, and is of particular concern amongst young people, with an estimated 65% of young women likely to have been on fad diets at some time.<sup>18</sup> Fad dieting is a risk factor for both underweight and overweight, because in the long term young people who diet are likely to gain more weight than those who do not diet, but at the same time, they are also at increased risk of eating disorders. Eating disorders such as anorexia nervosa affect a smaller proportion of the community, but can lead to severe underweight and can be life threatening.

Research in the City of Port Phillip has identified that many disadvantaged groups do not have secure access to affordable and nutritious food.<sup>19</sup> The most vulnerable groups have been identified as

- People living in poverty
- Families with children
- Young people
- Older people
- Indigenous Australians
- Ethnic groups
- People with a disability

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<sup>17</sup> Chapman, K. Nicholas, P. & Supramaniam R. 'How much food advertising is there on Australian television?' *Health Promotion International* Advance Access published on July 11, 2006 Health Promot. Int. 2006 21: 172-180; doi:10.1093/heapro/dal021 accessed 30 October 2006

<sup>18</sup> For more information on Fad dieting see the Victorian Government 'Go for your life' website at [http://www.goforyourlife.vic.gov.au/hav/site.nsf/showresults?open&c=top&v=101&j=.9713126&jz=everyone&tx=fad\\_diets](http://www.goforyourlife.vic.gov.au/hav/site.nsf/showresults?open&c=top&v=101&j=.9713126&jz=everyone&tx=fad_diets) (accessed December 2006)

<sup>19</sup> B Wood & P Streker *Food Security in the City of Port Phillip Report Part V* City of Port Phillip, 2005 available at <http://www.portphillip.vic.gov.au/attachments/o14647.pdf> (accessed December 2006)

- People experiencing homelessness
- People with alcohol and drug issues
- Street sex workers

Improving food security, defined as "the state in which all persons obtain a nutritionally adequate, culturally acceptable diet at all times through local non-emergency sources",<sup>20</sup> has been identified as a priority. Key barriers to food security in the local government area are gentrification, transport barriers and inequitable local food access. ISEPICH Nutrition and Food Security Action Group in 2004-06 undertook a survey of key stakeholders in the ISEPICH catchment on food security. Twenty ISEPICH member agencies responded to the survey. The survey indicated that while there is concern about food security across the catchment, capacity to address the issue varies. The goal for this priority area in 2006-09 has been identified as increasing capacity to address nutrition and food security.

The Department of Human Services has produced a number of resources on evidence based promotion of healthy eating including *Promoting Healthy Eating for Children*<sup>21</sup>, *Shapes: Body Image Program Planning Guide*,<sup>22</sup> and Garrard et al *Planning for Healthy Communities* (in particular Chapter Eight)<sup>23</sup>.

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<sup>20</sup> *Ibid* p 2

<sup>21</sup> Available at <http://www.nphp.gov.au/publications/phpractice/planfrwk.pdf> (accessed 5 December 2006).

<sup>22</sup> Available at <http://www.nphp.gov.au/publications/phpractice/planfrwk.pdf> (accessed 5 December 2006).

<sup>23</sup> Available at [http://www.health.vic.gov.au/healthpromotion/downloads/ch\\_8.pdf](http://www.health.vic.gov.au/healthpromotion/downloads/ch_8.pdf) (accessed 5 December 2006).

### 3. Solution generation

The tables below provide summaries of proposed goals, objectives and strategies, and estimated timelines, resources, and impacts for the three priority areas. This information is also available on QIPPS and will be progressively updated as the planning process continues. Please note that in most cases the information applies only to the 2006-07 year. The plan will be progressively updated.

<b>HP Priority goal:</b>	To improve mental wellbeing in the ISEPICH catchment.					
<b>Objective(s):</b>	<ol style="list-style-type: none"> <li>1. By September 2007, to develop a catchment mental wellbeing promotion plan for ISEPICH. (This IHPP will be updated to reflect the plan at that time).</li> <li>2. To implement and evaluate the mental wellbeing plan in 2007 - 2009.</li> <li>3. To support ongoing partnership initiatives aiming to promote mental wellbeing in the ISEPICH catchment, including: <ul style="list-style-type: none"> <li>• Welfare to Work research and advocacy project</li> <li>• Advocacy to increase affordable housing in the catchment</li> <li>• Agreed approach to settings-based Health Promotion in Rooming Houses in the catchment</li> <li>• Building the capacity of ISEPICH agencies to provide inclusive health promotion and services.</li> </ul> </li> </ol>					
<b>Estimated impacts<sup>1</sup> (qual/quant)</b>	<ol style="list-style-type: none"> <li>1. Increased knowledge of mental wellbeing promotion in PCP member agencies. Endorsement of plan by Executive, Health Promotion Working Group, ISMHA and member agencies. Agreed roles and responsibilities for implementation</li> <li>2. Impacts will be added when the plan is developed</li> <li>3. A summary is provided below – see individual plans for details</li> </ol>					
<b>Key strategies</b>	<b>Key implementation partners</b>	<b>Population target group/s:</b>	<b>Estimated timelines (optional)</b>	<b>Estimated reach</b>	<b>Estimated intervention resources per member<sup>24</sup></b>	<b>Estimated impacts</b>
<b>Objective 1</b>						
Workshop on mental health promotion to be held by April 2007 Organisational and workforce development (this may be combined with workshop on	Working party drawn from Executive, ISMHA and Health Promotion Working Group, Community Representatives, ISEPICH staff.	Senior and middle management in agencies	April 2007	Senior /middle management in at least 12 agencies	ISEPICH staff time c 80 hours (\$5200) Other ISEPICH (catering Honorariums etc) (\$2000) Working party (6) total c 10 hours each (\$3900) Total \$11100	Increased knowledge of mental wellbeing promotion.

<sup>24</sup> For the purpose of this budget, all paid workers' time is costed at an average of \$65 per hour (please note this is higher than the DHS recommended rate for health promotion, as staff involved in PCP activities are often at a relatively senior level in organisations). Community representatives' time is costed at \$40 honorarium per session. ISEPICH has a payment policy for community representatives; a copy is available on request.

health inequalities)						
Disseminate discussion paper on mental health promotion, develop definition (April – June 2007)	Lead agency (to be determined), plus Working group drawn from Councils, Community Health Services, Port Phillip Community Group, Mental health services, Prahran Mission, other agencies, Community representatives	Definition - All member agencies, plus community representatives  Sign off - All member agencies and CAG	Definition finalised by July 2007	All ISEPICH agencies and community representatives	Lead agency – 20 hours (1300). Working group members (6) – c 10 hours each (\$3900). ISEPICH staff – 80 hours (5200). Total \$10400.	
Develop catchment mental wellbeing plan (July - September 2007)	As above	Commit to implementation of plan – at least 12 member agencies	Plan signed off by September 2007	All ISEPICH agencies and community representatives	ISEPICH staff 80 hours (5200) . Lead agency 20 hours (1300). Working group members (6) five hours each (1950). Total 8450. <b>Total for Objective 1 \$29950</b>	Endorsement by Executive, Health Promotion Working Group, ISMHA and member agencies. Agreed roles and responsibilities for implementation
<b>Objective 2</b>						
Implement mental wellbeing plan	To be determined					
<b>Objective 3</b>						
Welfare to Work Action Research project (Detailed plan on QIPPS)	Port Phillip Community Group (Lead agency), Community representatives, ACOSS, RMIT students	People affected by Welfare to Work changes Member agencies Policy makers	2006-09	20+ agencies, 40 community members	Lead agency – c150 hours (9750). ISEPICH staff – c50 hours (3250). Community representatives (2) 80 hours total (3200), Students and other volunteers – 200 hours (free). Total \$16200.	Increased knowledge of impact of Welfare to Work changes by agencies and community  Advocacy/empowerment for people affected, as determined by findings of action research project
Affordable housing advocacy (Detailed	Community representatives,	Policy makers,	2006-09	Policy makers in	ISEPICH staff time – c 40 hours (2600)	Continued support by member agencies for increased

plan on QIPPS)	Councils, VCOSS	government (all levels)		three Councils and state/federal government		affordable housing in the catchment
Settings based health promotion (See ISCHS IHP plan, and QIPPS)	Inner South Community Health Service (lead), Port Phillip Community Group, Housing services, Mental health services, City of Port Phillip, City of Stonnington, Caulfield CHS, Community Representatives	Agencies and workers working with Rooming Houses (20+) Office of Housing Residents of 68 Rooming Houses in catchment	Agreed approach by April 2007. Ongoing implementation.	20+ agencies, 4 Rooming Houses (year one)	Lead agency – c 20 hours (1300). ISEPICH staff c 20 hours (1300), Working group members (6) – c 4 hours each (1560). Community representatives (2) – c 10 hours total (400) Total \$4560	Agreed approach to the delivery of settings based health promotion between residents, housing providers, Office of Housing and support agencies. Ongoing implementation and evaluation.
Inclusive health promotion (Detailed plan on QIPPS)	South Central Migrant Resource Centre (lead), City of Port Phillip, City of Stonnington, City of Glen Eira, Community Representatives	Member agencies (20+) Culturally and linguistically diverse community members	Increased knowledge re small and emerging communities by April 2006	20+ agencies,	Lead agency – 20 hours (1300), ISEPICH staff 20 (1300), working group (4) – 4 hours each (1040) – community representatives (1) 4 hours (160) Total \$3800 <b>Total budget for Objective 3 \$27160</b>	Increased knowledge of needs of CALD communities by agencies Increased participation in health promotion activities by CALD communities Improved access to services for CALD communities
<b>Estimated total budget per objective:</b> 2006-07 - Objective 1 \$29950 (PCP \$17600) Objective 3 \$27160 (PCP 12,210)						
<b>Estimated total budget per goal:</b> 2006-07 \$57110 (PCP 29810)						

**Priority goal: To improve the health of the local community through increased physical activity levels.**

<b>HP priority goal</b>	To improve the health of the local community through increased physical activity levels.					
<b>Objective(s):</b>	<ol style="list-style-type: none"> <li>1. By April 2007, to develop a catchment physical activity promotion plan for ISEPICH. (This IHPP will be updated to reflect the plan at that time).</li> <li>2. To implement and evaluate the physical activity promotion plan in 2007-09.</li> <li>3. To support ongoing partnership initiatives aiming to increase physical activity within the ISEPICH catchment, including: <ol style="list-style-type: none"> <li>a. Healthy and Active Living for Seniors funded project</li> <li>b. Strength Training Network</li> <li>c. Falls Prevention Community Network (including funded Falls Prevention project in ISEPICH and Kingston Bayside PCP)</li> </ol> </li> </ol>					
<b>Estimated impacts<sup>1</sup> (qual/quant)</b>	<ol style="list-style-type: none"> <li>1. Plan endorsed by Executive, ISEPICH member agencies, Health Promotion Working Group, agencies committed to implementing the plan, agreed roles and responsibilities, plan reflected in agency organisational plans.</li> <li>2. Implementation of the physical activity promotion plan in 2007-09</li> <li>3. Continued PCP support for ongoing interventions (for impacts of the interventions please see individual plans)</li> </ol>					
<b>Summary of mix of interventions<sup>2</sup></b>	<b>Key implementation partners</b>	<b>Population target group/s:</b>	<b>Estimated timelines (optional)</b>	<b>Estimated reach</b>	<b>Estimated intervention resources per member</b>	<b>Estimated impacts</b>
<b>Objective 1</b>						
Workshops will be held by the Physical Activity Group during November 2006- April 2007 to develop the plan using the NPHP framework as a planning tool	Caulfield Community Health Service (lead agency), Monash GP Division, International Diabetes Institute, Bentleigh Bayside Community Health Service, Inner South Community Health Service, Vision Australia Foundation, City of Port Phillip (MetroActive), City of Glen Eira, City of Stonnington, Community Representatives	Member agencies, including senior/middle management	November 2006- April 2007	Workshops – 20+ agencies Sign off - Health Promotion Working Group, Executive, member agencies (47) Implementation – 12+ agencies	ISEPICH staff time c 180 hours (11700). Other ISEPICH (catering, honorariums etc) (\$2600). Working group convenor c40 hours (\$2600). Working group members (9) c20 hrs each (\$11700) <b>Total \$28600</b>	Plan endorsed by Executive, ISEPICH member agencies, Health Promotion Working Group, agencies committed to implementing, agreed roles and responsibilities, Plan reflected in organisational plans.
<b>Objective 2</b>						

To be determined when plan finalised			May 2007 – September 2009			
<b>Objective 3 (summaries)</b>						
Healthy and Active Living for Seniors funded project (Plan to be available on QIPPS)	Caulfield Community Health Service (lead), International Diabetes Institute, City of Port Phillip, City of Glen Eira, City of Stonnington, Inner South Community Health Service, Community Representatives	Seniors	January 2006 – December 2008	25% of older adult population	\$20000 in 2006-07 (\$40000 DVC funded project). ISEPICH staff time 20 hours (\$1300). Steering committee (6) 6 hours each (\$2340). Total \$43640.	Increase in supportive environments. Increased walking.
Strength Training Network (Plan to be available on QIPPS)	International Diabetes Institute (convenor), Caulfield Community Health Service, Benteigh Bayside Community Health Service, Inner South Community Health Service, MECWA	Seniors (including CALD), service providers	Ongoing	500+ participants	Network capacity building – convenor 20 hours (1300), working group members (5) 10 hours each (3250). ISEPICH staff time 4 hours (260) Total \$4810. Strength training programs – see agency plans.	Increased knowledge in providers and community. Improved health and wellbeing of participants
Falls Prevention Community Network (Plan to be available on QIPPS)	Bentleigh Bayside Community Health (lead), City of Port Phillip, City of Glen Eira, Caulfield Community Health Service, City of Stonnington, Inner South Community Health Service, Volunteer Peer Educators	Seniors (including CALD and people with chronic illness, disadvantaged groups) and service providers	July 2006-June 2009	To be determined (project plan in preparation)	\$30000 in 2006-07 (ISEPICH) (\$310,000 DHS funded project over 3 years for ISEPICH and Kingston Bayside PCPs) ISEPICH staff time 20 hours (1300) Steering committee (4) 6 hours each (1560). Total \$32860.	Increased knowledge about falls in target populations. Decrease in falls by seniors in catchment.
<b>Estimated total budget per objective:</b> Objective 1 July 2006-April 2007 \$28600 (PCP budget \$14300). Objective 3 2006-07 \$81310 (PCP 2860).						
<b>Estimated total budget per goal:</b> July 2006-April 2007 \$109910 (PCP 17160).						

**Priority goal: To increase capacity within the ISEPICH catchment to address nutrition and food security.**

<b>Objective(s):</b>	<ol style="list-style-type: none"> <li>By April 2007, to develop a nutrition and food security promotion plan for ISEPICH.</li> <li>To implement the nutrition and food security promotion plan in 2007-09.</li> <li>To support ongoing partnership initiatives aiming to promote nutrition and food security in the ISEPICH catchment.</li> </ol>					
<b>Estimated impacts<sup>1</sup> (qual/quant)</b>	<ol style="list-style-type: none"> <li>Plan developed, and endorsed by Executive, Health Promotion Working Group, and member agencies. At least 12 committed to implementing the plan. Agreed roles and responsibilities. Plan reflected in agency organisational plans</li> <li>To be developed as part of the plan.</li> <li>To be developed as part of the plan.</li> </ol>					
<b>Summary of mix of interventions<sup>2</sup></b>	<b>Key implementation partners<sup>3</sup></b>	<b>Population target group/s:</b>	<b>Estimated timelines (optional)</b>	<b>Estimated reach<sup>4</sup></b>	<b>Estimated intervention resources per member<sup>5</sup></b>	<b>Estimated impacts</b>
<b>Objective 1</b>						
Workshops will be held by the Nutrition and food security Group during November 2006 - April 2007 to develop the plan using the NPHP framework as a planning tool	City of Stonnington (lead agency), Inner South Community Health Service, Community Representatives, Caulfield Community Health Service, Bentleigh Bayside Community Health Service	Member agencies, including senior/ middle management	By April 2007	Workshops – 20+ agencies Sign off -Health Promotion Working Group, Executive, ISEPICH member agencies (47) Implementation – 12+ agencies	SEPICH staff time c 180 hours (\$11700). Other ISEPICH (catering, honorariums etc) (\$2600). Working group convenor c40 hours (\$2600). Working group members (9) c20 hrs each (\$11700) <b>Total for objective 1 July 2006 - April 07 \$28600</b>	Plan endorsed by Executive, Health Promotion Working Group, and member agencies. Agencies committed to implementing. Agreed roles and responsibilities. Plan reflected in organisational plans
<b>Objective 2</b>						
To be determined as part of the plan			May 2007- September 2009			
<b>Objective 3</b>						
To be determined as part of the plan			Ongoing			
<b>Estimated total budget per objective:</b> Objective 1 July 2006-April 2007 \$28600 (PCP 14300)						
<b>Estimated total budget per goal:</b> July 2006 - April 2007 \$28600 (PCP 14300)						

## 4. Capacity building

The table below summarises capacity building objectives across all priority issues for 2006-07. Further detail is available in the ISEPICH Health Promotion Plan on QIPPS.

Objectives	Interventions	Theme	What would potentially be changed/different? impacts
<i>By September 2007, catchment plans for the three priority areas of mental wellbeing, physical activity and nutrition &amp; food security to developed and signed off by ISEPICH</i>	<i>Series of workshops 2006-07 to develop integrated plan for each priority, using NPHP framework as key resources (for further details see program plans)</i>	Organisational development Partnership development Workforce development	Plans developed and signed off by Health Promotion Working Group, Executive, and member agencies (Further details of estimated impacts for each priority issue are available in program plans); Plans reflected in organisational plans of member agencies; Links between Service Coordination, Integrated Chronic Disease Management and Integrated Health Promotion to be documented in plans; Partnerships (existing and new) to be documented in plans; Opportunities for integrated health promotion addressing all three priority issues to be documented in plans
<i>By September 2007, develop a draft framework for addressing health inequalities in ISEPICH</i>	<i>Provide workshops on health inequalities and develop health inequalities/access and equity framework.</i>	Leadership Organisational development	Draft Framework and resources to be endorsed by ISEPICH Executive for consultation; Increased knowledge of health inequalities in at least 20 member agencies;
<i>By September 2007, develop an agreed approach to community participation in health promotion in ISEPICH</i>	<i>Workshop/s in 2007 to develop and document agreed approach</i>	Organisational development Partnership development	Increased knowledge of community participation in agencies and workforce; Community representatives feel empowered to participate in health promotion; Health promotion working groups have effective community representation
<i>BY September 2007, increase leadership/management support for health promotion in ISEPICH</i>	<i>Learning process with DHS support (potentially combined with health inequalities workshops)</i>	Leadership Organisational development	IHP leadership embedded within organisations - leaders/champions identified within at least 20 PCP member agencies at senior and/or middle management level
<i>In 2006-07, continue to increase individual knowledge and skills in Integrated Health Promotion in ISEPICH</i>	<i>Continue IHP training with southern region PCPs and DHS. Include workshops on health inequalities and diversity</i>	Workforce development	Increased health promotion knowledge in workers from member agencies(at least 15) and community representatives and/or community members (at least six); Improved health promotion practice by workers (at least 15)

#### 4.1 Resources – PCP IHP Catchment Resource Summary

##### Estimated Integrated Health Promotion (IHP) PCP resource allocation for 2006-07 year

Capacity building components	DHS funded PCP IHP	Member contributions
Partnership development	12000	7400
Leadership	12000	7400
Organisational development	22200	13800
Planning for evaluation and dissemination	7000	4350
Workforce development	13000	8000
<b>Estimated Total PCP resource/budget allocation</b>	<b>\$66200</b>	<b>\$40950</b>

##### Provide information of other resources that will be used to support the IHP catchment work.

Partnership funding for Community Representative Honorariums \$6000

##### Additional Integrated Health Promotion Resources

Funding source/project	Links to catchment priority	Funding
HALS funding	Physical activity	20,000 (2006-07)
Whole of community falls prevention (with Kingston Bayside PCP)	Physical activity	30,000 (Total for 2006-07 is 60,000 - 30,000 to KBPCP)
<b>Totals</b>		<b>50,000</b>

## **5.1 Planning for quality health promotion practice (*Evaluation of mix of interventions*)**

### **How will the PCP facilitate and support evaluation processes conducted by the agencies around the priorities?**

Evaluation will be addressed as part of the catchment planning process. ISEPICH has begun using QIPPS for catchment planning and the use of QIPPS for planning and evaluation by member agencies will be supported and facilitated.

### **What processes will the PCP use to obtain an evaluation of the work around the priorities across the whole PCP catchment?**

ISEPICH developed a draft catchment evaluation framework for the mental wellbeing and social connectedness priority area in 2004-05 and will build on this in developing catchment evaluation for the priority areas in 2006-09, utilising QIPPS and the DHS evaluation planning framework as resources. The draft ISEPICH catchment evaluation framework aims to make clear the links between evaluation of initiatives within the catchment and broader population and community indicators in order to show the ways in which local projects are contributing to the bigger picture in population health and health promotion.

Seven thousand dollars has been allocated to planning for evaluation and dissemination. Depending on needs identified in the catchment planning process, this can be used for support from the PCP health promotion coordinator, training and professional development or report production and dissemination. The bulk of the resources (probably about 75%) are expected to be used for building capacity in evaluation, but a proportion will be earmarked for assisting working groups and individuals to publish and disseminate their work to a wider audience.

## 5.2 Evaluation and dissemination (Evaluation of capacity building strategies)

**What are the processes the PCP will employ to measure progress towards achieving the capacity building objectives detailed in the previous section?**

The ISEPICH Health Promotion Plan on QIPPS utilises the QIPPS evaluation framework. The draft evaluation table is shown below and the full Plan is available on request.

<b>Program Goal</b>	To build capacity for effective health promotion to address priority issues in ISEPICH	
<b>Population Target Group/s</b>	1. Community representatives 2. Member agencies	
<b>Objective 1</b>	By September 2007, catchment plans for the three priority areas of mental wellbeing, physical activity and nutrition & food security to developed and signed off by ISEPICH	
	<b>Performance Indicators</b>	<b>Evaluation Method</b>
<b>Process</b>	Reach - agencies endorsing plans, participating in process, committed to implementation of plans, strategies reflected in organisational plans Feedback on process by participants	Documents - reports and minutes of workshops and working groups, draft plans and comments received Evaluation forms and discussions with participants
<b>Impact</b>	Plans developed and signed off by Health Promotion Working Group, Executive, and member agencies (Further details of estimated impacts for each priority issue are available in program plans); Plans reflected in organisational plans of member agencies; Links between Service Coordination, Integrated Chronic Disease Management and Integrated Health Promotion to be documented in plans; Partnerships (existing and new) to be documented in plans; Opportunities for integrated health promotion addressing all three priority issues to be documented in plans	Documents - plans, endorsement of plans by Health Promotion Working Group, Executive and member agencies (minutes of meetings). Strategies in member agencies' organisational plans - audit of organisational plans. Documentation in plans of: links between Service Coordination, Integrated Chronic Disease Management and Integrated Health Promotion; partnerships; opportunities and plans for interventions addressing all three priority issues
<b>Objective 2</b>	By September 2007, develop a draft framework for addressing health inequalities in ISEPICH	
<b>Process</b>	Reach - Executive and member agencies Participation in workshops Feedback from participants	Documents - records of meetings and workshops Evaluation forms and discussion with participants in workshops
<b>Impact</b>	Draft Framework and resources to be endorsed by ISEPICH	Documents - minutes of meetings Evaluation forms at

	Executive for consultation; Increased knowledge of health inequalities in at least 20 member agencies;	workshops to identify whether participants' knowledge increased
<b>Objective 3</b>	By September 2007, develop an agreed approach to community participation in health promotion in ISEPICH	
<b>Process</b>	Reach - community representatives and agency representatives in workshops; sign off of approach by agencies and CAG. Feedback by participants on workshops and document.	Documents - records and minutes of meetings. Evaluation form and discussion with participants at workshop
<b>Impact</b>	Increased knowledge of community participation in agencies and workforce; Community representatives feel empowered to participate in health promotion; Health promotion working groups have effective community representation	Evaluation form to assess whether participants' knowledge increased; Community representatives to feedback to CAG on their experience in participation (whether empowered); Documents - minutes and records of meetings re attendance and participation of community representatives
<b>Objective 4</b>	By September 2007, increase leadership/management support for health promotion in ISEPICH	
<b>Process</b>	Reach - number of agencies represented at workshop, level of management represented; Feedback from participants in workshop	Documents - minutes and records of meetings and workshop. Evaluation form and discussion with participants in workshop.
<b>Impact</b>	IHP leadership embedded within organisations - leaders/champions identified within at least 20 PCP member agencies at senior and/or middle management level	Documents - records of individuals who identify as leaders/champions of health promotion in agencies. Evaluation by Health Promotion Working Group and priority area action groups re whether support for health promotion has increased (agenda item for discussion)
<b>Objective 5</b>	In 2006-07, continue to increase individual knowledge and skills in Integrated Health Promotion in ISEPICH	
<b>Process</b>	Reach - number of introduction to health promotion workshops, number of workers and community representatives participating in workshops. Feedback from participants on workshops.	Documents - records of meetings and workshops. Evaluation form at workshops.
<b>Impact</b>	Increased health promotion knowledge in workers from member agencies(at least 15) and community representatives and/or community members (at least six), Improved health promotion practice by workers (at least 15)	Evaluation form to ask whether participants' knowledge increased. Follow up of participants by later survey to assess impact on practice (probably with DHS SMR).

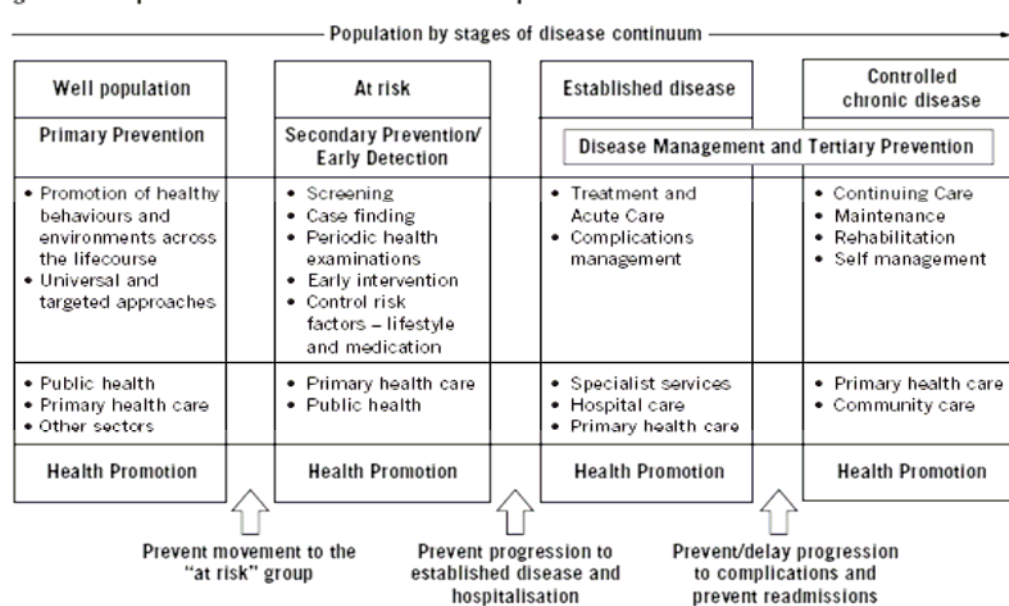
## How will the PCP facilitate the dissemination of learning, including unexpected results?

We will aim to publish the results on the public section of QIPPS as well as continuing to use the ISEPICH website. We will also seek opportunities for publication and presentation where relevant.

## 6. Applying an Integrated Disease Management 'lens' to IHP planning

ISEPICH will utilise the NPNP model, below,<sup>25</sup> to identify the key points for health promotion to address chronic disease. In each priority area, the catchment plans will identify interventions directed towards the general population (this includes interventions that are directed towards different stages of the life course or culturally and linguistically diverse groups), those directed towards "at risk" groups or people with early signs of disease, and those directed towards people with established and controlled disease (for example support groups).

Figure 3: Comprehensive model of chronic disease prevention and control



<sup>25</sup> NPHP 2001, Preventing Chronic Disease: A strategic Framework – Background Paper. Melbourne, NPHP. Available from: <http://www.nphp.gov.au/publications/strategies/chrondis-bgpaper.pdf>