



Community Health Plan 2006 - 2009

Deliverable 1: Partnership

October 2006

Endorsed by PCP Chair:

Name: Nola Maxfield

Signature:

Date: 09/11/2006

1. Partnership vision

What is the agreed vision for the PCP partnership for the period 2006–09?

The South Coast Health Services Consortium completed a strategic planning exercise in September 2006. The strategic planning exercise was assisted by LIME Management Group.

The Vision Statement resulting from the strategic planning process and endorsed by the Consortium is

“Local Health services working together collaboratively and effectively to ensure that all services are integrated and coordinated around the needs of people living in the South Coast”

2. Achieving the vision: *priority setting and problem definition*

What are the key challenges to be addressed to achieve the vision?

The key components of the Action Plan resulting from the strategic planning exercise are:

Vision and Scope

Update the terms of reference including the vision/mission statement to reflect the agreed broad whole of health focus.

Governance

Broaden the scope and governance structure of Consortium to encompass two key divisions.

. Planning

. PCP

Membership

Review membership scope and types to ensure it is inclusive of appropriate organisations and develop mechanisms to ensure engagement

Funding

Agree and establish a funding mechanism for the Planning Division

Branding

Review the SCHSC name and key messages

Decision Making

Establish decision making structures which involve both CEO's and Program Managers as appropriate and develop mechanism to inform the GHSP.

3. Achieving the vision: *Capacity Building Plan*

Refer to Section 2:

Element: (if using capacity building elements)

Goal	Objective	Strategies/Interventions	Estimated Impact

Element:

Goal	Objective	Strategies/Interventions	Estimated Impact

Make additional copies of the table for each element.

4. List of PCP member agencies/organisations and explanation of membership types

Agency name	Type of membership	Deliverable/s involved in
Bass Coast Community Health Service	Full Member	
Bass Coast Regional Health	Full Member	
Bass Coast Shire Council	Full Member	
Gippsland Southern Health Service	Full Member	
KoWeeRup Regional Health	Full Member	
Latrobe Community Health Services Inc	Full Member	
General Practice Alliance - South Gippsland	Full Member	
South Gippsland Hospital	Full Member	
South Gippsland Shire Council	Full Member	
Warley Hospital	Full Member	
Yarram and District Health Service	Full Member	
Allied Health Services –Gippsland Southern Health Services	Associate Member	
BaptCare – Gippsland	Associate Member	
Department of Victoria Communities – Gippsland	Associate Member	
Gippsland Women's' Health Service	Associate Member	

Gippsport	Associate Member	
Kilmany UnitingCare	Associate Member	
Mental Illness Fellowship (Victoria) Ltd – Wonthaggi Office	Associate Member	
Milpara House	Associate Member	
South West Gippsland Mental Health Services	Associate Member	
Villa Maria	Associate Member	
YMCA – Bass Coast	Associate Member	



Community Health Plan 2006 - 2009

Deliverable 2: Integrated Health Promotion

October 2006

Endorsed by PCP Chair:

Name: Nola Maxfield

Signature:

Date: 09/11/2006

1. IHP vision

“Integrated health promotion in the South Coast Health Services Consortium PCP (SCHSC) will enable a coordinated collaborative approach between PCP agencies and stakeholders to promote health for disadvantaged groups and individuals in the community.

“Through the Integrated Health Promotion Plan the PCP will build partnerships to allow for collaborative delivery of interventions across the catchment which include all potential partners. The South Coast Health Services Consortium will provide local information to allow PCP member agencies to deliver health promotion interventions under the identified catchment priorities to those of greatest need in their communities. PCP member agencies will be provided with support in identified areas of need which includes workforce development and information dissemination about health promotion and the health promotion priorities for the catchment.”

2. Priority setting and problem definition

To determine priorities for health promotion for this planning period, a series of workshops and surveys were conducted. PCP member agencies were asked to respond to a survey to review the 2004 – 06 health promotion priority areas and to identify any new areas considered as important to the South Coast Health Services Consortium area. Overwhelming support was given to the existing priority areas with respondents considering there was still a lot of work to be done in all of the areas and expressing a need to continue some activities established in the preceding plans.

A workshop was convened to discuss these findings and to look at the evidence for continuation with existing priority areas and to further identify specifically how these priority areas would be addressed. Each priority area was discussed in relation to the following questions: What do we know about this issue? How do we know this? What have we observed/been told/read about? What are we already doing ourselves and what changes have we seen? Who is affected? Who will be the target group? What are the factors that contribute to this to be a problem (behavioural and social factors)? What consultation has there been with stakeholders? What might be amenable to change?

This problem definition process identified specific focus within each priority area which, although they resemble priority areas of the past, now have a more specific approach to the environmental influences contributing to health in the area. It is to be noted that all these priority areas, once again align with those of the state and commonwealth governments.

Increasingly our environment is being recognised to have considerable influence on our health. It is influential in providing access or barriers to physical activity opportunities and healthy eating.¹ Much of our community reside in areas where access to community activities which allow community connectedness are limited. Those who are socially isolated and economically disadvantaged are more at risk of experiencing poor mental health.² In turn, those who are suffering from poor mental health have a reduced desire to be physically active³ and are less likely to eat an adequate diet. These people will also be more likely to experience difficulty accessing healthy food in the local community setting.

¹ Matson-Kiffman DM, Brownstein JN, Neiner JA and Greany ML (2005) a site specific literature review of policy and environmental interventions that promote physical activity and nutrition for cardiovascular health: What works? *American Journal of Health Promotion* 19(3): 167-97

² VicHealth (2005) A Plan for Action 2005 – 2007 *Victorian Health Promotion Foundation, Carlton*

³ Dowd, Vickers and Krahn (2004) in VicHealth (2005) above.

Each person in the South Coast community is part of the broader physical, information and social cultural environment and how they interact with that environment depends on many factors including policy, settings, perceptions and behavioural characteristics.

Distance and lack of access to public transport affects the capacity of rural people to form social connections, access to healthy and affordable food and access to group physical activity opportunities. Perceptions of safety, accessibility and aesthetics can restrict some people to interact with their community for social inclusion, physical activity or accessing healthy food.

These barriers are particularly evident to socio-economically disadvantaged groups who perceive the cost and availability of fruits and vegetables to be prohibitive in comparison to high energy dense foods.⁴ Although location to shops is a factor in urban settings where studies were conducted on a 2.5 – 5km radius of the store, it is important to note that the majority of those in lower socio-economic groups in South Gippsland and Bass Coast reside outside these areas and many on farms⁵.

Identification of who is experiencing difficulties accessing services, food and social activities is needed in this area to allow for interventions to be put in place to assist better access. Although there is considerable data to identify certain groups and individuals as likely beneficiaries of health intervention, there is little collated data available to the local area which summarises this information. As such part of the first year of the plan will be to collect the sources of the data and collate a local profile of the socially disadvantaged groups and individuals in the area. This will allow specifically targeted interventions to take place in the subsequent years.

The focus on environments for physical activity and access to healthy and affordable food are extensions of the more general physical activity and nutrition priorities of past plans and are therefore in early development stages. This is reflected in preparatory strategies such as forums and data gathering of this plan. This plan will allow for emerging activities and objectives and will also allow for directions to be set by new partnership groups which develop as a result of this plan and will encourage more collaboration in different ways from existing partners.

⁴ Inglis V, (2006) The influence of food availability, access and affordability on dietary behaviours of women from different socioeconomic backgrounds *Sowing the Seeds Forum, (September 2006, Dandenong)*

⁵ Winkler E, Turrell G, Patterson C (2006) Does living in a disadvantaged area mean fewer opportunities to purchase fresh fruit and vegetables in the area? Findings from the Brisbane food study. *Health and Place 12(3) pp306-319.*

Target populations for the Community Health Plan.

The target populations for all priority areas are socially isolated, disadvantaged people. There is a lot of work to be done in the first year of the Community Health Plan to collect new data and collate existing data to better inform the PCP on details of this target group. Due to the capacity building nature of this plan, many strategies target member agency staff.

Links with other plans

Both the South Gippsland and Bass Coast Municipal Public Health Plan planning cycles are out of line with the Community Health Planning for the PCP. The Municipal Public Health Plan for the South Gippsland Shire Council has just been passed by the council in late September 2006. The Bass Coast Shire Municipal Public Health Plan has been rewritten and passed in the last year also. Both Shires ensured key health planners were available for the PCP Health Promotion Planning Workshops which took place late 2005 and early 2006. Ongoing work will occur between PCP staff and Shire staff to align both plans and identify common intersections and implement shared interventions.

Priority Goals**Physical Activity**

To increase opportunity for participation in physical activity in the South Coast area.

Access to Healthy and Affordable Food

To identify and address barriers to accessing healthy and affordable food in the South Coast area.

Mental Health and Wellbeing

To promote mental wellbeing a social inclusion in the South Coast area.

3. Solution generation

Mix of interventions

All community and women's health member agencies have plans which reflect at least one of the SCHSC priorities. Details of the mix of interventions used in their plans can be seen by accessing the plans via the links provided in blue below. Also accessible via the blue references are the *Health and Wellbeing in the Bass Coast* and the *South Gippsland Shire Health and Wellbeing Plan*.

CURRENT FULL MEMBERS WITH HEALTH PROMOTION PLANS LINKED WITH THE SCHSC COMMUNITY HEALTH PLAN

<p>Ms Heather Johnson CEO Bass Coast Community Health Service.</p> <p>Bass Coast Community Health Service Integrated Health Promotion Plan 2006 - 2009</p>	<p>Ms Margaret Gerkens CEO South Gippsland Hospital (Foster)</p> <p>South Gippsland Hospital Integrated Health Promotion Strategic Plan 2006 - 2009</p>	<p>Ms Judy Abbey Director Community Services & Facilities Gippsland Southern Health Service</p> <p>Gippsland Southern Health Service Integrated Health Promotion Plan 2006 - 2009</p>	<p>Ms Colleen Boag Acting Executive Director Yarram & District Health Service</p> <p>Yarram and District Health Service Integrated Health Promotion Plan 2006 - 2009</p>
<p>Rosemary James Senior Manager (Acting), Community Services South Gippsland Shire Council</p> <p>South Gippsland Shire Council Public Health and Wellbeing Plan</p>	<p>Ms Jeanette Draper Community Development Officer/Social Planner Bass Coast Shire Council</p> <p>Health and Wellbeing in Bass Coast</p>		

4. Capacity building

Summary table capacity building objectives

Priority goal: Environments for Physical Activity To increase opportunity for participation in physical activity in the South Coast Area.	
Theme	Objectives
Organisational development	Objective 1 To further align the Municipal Public Health Plans and Integrated Health Promotion Plans of the Bass Coast and South Gippsland Shires and South Coast Health Services Consortium to show shared objectives and interventions in each shire by the end of the plan.
Partnerships	Objective 2 To enhance and increase partnerships between government, non-government, the private sector and community organisations to address barriers to physical activity in the environment over the life of the plan. Objective 3 To increase use of under-utilized community facilities for physically active recreation purposes with partners in the industry.
Leadership	Objective 4 To extend the understanding and skills of the processed for catchment planning and evaluation for health promotion in all agency staff by 2009.
Workforce development	Objective 5 To extend the understanding of integrated health promotion and its aims in all agency staff by 2009.

Priority goal: Access to Healthy and Affordable Food	
To identify and address barriers to accessing healthy and affordable food in the South Coast area.	
Theme	Objectives
Organisational development	
Partnerships	<u>Objective 6</u> To identify the physical, social, economic and cultural barriers to accessing and affording healthy food in the PCP catchment by June 2007.
Leadership	<u>Objective 7</u> To resource member agencies and local organisations with local, up-to-date information on barriers to accessing healthy and affordable food in the PCP catchment which will, in turn allow planning for local needs by June 2007. <u>Objective 8</u> To increase application of knowledge relating to healthy food to those people accessing community services by June 2009.
Workforce development	<u>Objective 6</u> To identify the physical, social, economic and cultural barriers to accessing and affording healthy food in towns of greatest need in the PCP catchment by June 2007. <u>Objective 8</u> To increase application of knowledge relating to healthy food to those people accessing community services by June 2009.

Priority goal: Mental Health and Wellbeing	
To promote mental wellbeing and social inclusion in the South Coast area.	
Theme	Objectives
Organisational development	
Partnerships	<u>Objective 9</u> To build capacity of organisations in the South Coast Health Services Consortium catchment to address mental health promotion and social inclusion through interventions by June 2009.
Leadership	<u>Objective 10</u> To analyse the pre-existing data highlighting social inequity in the South Coast area in relation to physical activity, nutrition and mental health and distribute to partners and organisations.
Workforce development	<u>Objective 11</u> To build capacity of organisations in the South Coast Health Services Consortium catchment to address mental health promotion and social support through interventions by June 2009.

Priority goal: Environments for Physical Activity

4.1 Organisational development

Objective 1

To further align the Municipal Public Health Plans and Integrated Health Promotion Plans of the Bass Coast and South Gippsland Shires and South Coast Health Services Consortium to show shared objectives and interventions in each Shire by the end of the plan.

Target Groups

PCP, agencies and Shire Councils.

Impacts

By 2009 shared objectives / strategies present on MPHP and CHP.

By 2009 intersections between Municipal Public Health Plan (MPHP), Community Plans, and Community Health Plans (CHP) explicit and described in latest versions of each plan.

By 2009 PCP represented on all relevant groups relating to MPHP, Community Plans, and Community Health Plans.

Strategies	Rationale	Reach	Evaluation
1. To participate in Bass Coast and South Gippsland MPHP reference groups.	To maintain contact with progress of MPHPs of both Shire Councils. To keep up to date with progress of local council strategies. To identify possible combined projects / strategies or support to MPHP.	2 meetings each year for each Shire Council.	Attendance recorded on minutes and increased alignment of CHP and MPHPs objectives and strategies.
2. PCP to attend existing Shire planning groups such as community planning and consultations groups and other intersecting groups as identified by PCP and Shire Councils	Intersections of MPHP / PCP Community Health Plan meetings and communication in place. Community plans will potentially inform future PCP / agency plans.	3 new meetings attended by HP officer. Increase in partnerships with different sectors of Shire and community.	Meeting notes, contacts established to community for attendance at forums, events, records of attendance.

3. To contribute to identified intersecting strategies with the Bass Coast and South Gippsland Shire Councils.	Intersection matrix identified within last CHP and current MPHPs.	1 shared project with each Shire.	Evaluation report from Shire project.
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4.2 Partnerships

Objective 2

To enhance and increase partnerships between government, non-government, the private sector and community organisations to address barriers to physical activity in the environment over the life of the plan.

Target Groups

Welfare agencies, Local Shire Councils – planners, developers, recreation officers, infrastructure staff, universities, recreation providers, schools, GPs, practice nurses.

Impacts

All organisations outside of government report an increased understanding of the processes within local government for planning.

A shared vision for promoting environments for physical activity developed and objectives for future action written. Partnerships developed to address this issue across the spectrum of local government, health promotion, planning, developers, health services and the community.

An incorporation of celebration of change and increased knowledge and ability to work together reported by organisations. Higher score on VicHealth Partnerships Analysis Tool checklist for this partnership.

Strategies	Rationale	Reach	Evaluation
<p>1. Conduct forum to attract interest in environments for physical activity in the area based on Healthy by Design principles.</p> <p>(Linked with GWHS mental health and wellbeing priority.)</p>	<p>Well planned neighbourhoods can increase the number of people engaging in physical activity. Awareness of these influences by Shire, community and health sectors can assist in developing stronger relationships for making change. Successful forums conducted in Baw Baw and with Kinect Australia.</p>	<p>Staff representatives from each Shire, health, planning, recreation departments, Rural Access Worker, Access for All Abilities worker, PCP agency staff, Health Promotion officers, General Practice Alliance – South Gippsland, GPs, DHS, DVC, recreation providers VicRoads, Gippsport, Schools, Tourism, Parks Victoria, Travelsmart, VicHealth, Planning Victoria, Neighbourhood Houses, Upright and Independent, Traffic engineers.</p>	<p>Forum conducted, pre and post evaluation, high profile speakers engaged, further action planned and documented.</p>

<p>2. Develop an Active Community Environments group with links to local government physical activity network.</p> <p>(SGH, BCCHS, Bass Coast Shire, South Gippsland Shire)</p>	<p>Existing in Baw Baw and Latrobe with Council members as active players. Progress made under these models.</p> <p>Healthy by Design Frameworks being incorporated into planning policy for Bass Coast Shire Council.</p> <p>Easy access maps being developed in Bass Coast and South Gippsland.</p> <p>Waterline project, community development</p> <p>Letters of support for small group grants.</p>	<p>1x group in Bass Coast of 10 members, 1x group in South Gippsland of 10 members.</p>	<p>VicHealth Partnership Analysis Tool pre-group and at 12 monthly intervals. Terms of reference, regular meetings, goals set, objectives outlined, joint strategies in place.</p> <p>Staff outside PCP driving activities identified relating to environments for physical activity.</p>
<p>3. Coordinate the promotion of the LifeScripts program through GP practices via practice nurses and General Practice Alliance – South Gippsland in partnerships with community health agencies.</p> <p>(SGH, YDHS, GSHS – elements of LifeScripts adopted and practices targeted depending on community health services involved and skill set / priorities of that service)</p>	<p>ActiveScripts / LifeScripts. LifeScripts package highly developed, work with General Practice Alliance – South Gippsland (GPA- SG) to capitalise on existing GP and practice nurse contacts.</p> <p>PCP has physical activity and nutrition links with community, GPA -SG has links with GP practices via GPs and Practice nurse network.</p>	<p>Reference group developed for training and information dissemination. Engage local agency staff.</p> <p>Develop link with agencies wanting to promote this link with GPs and medical practices.</p> <p>Pilot where most interest and agencies aligned first and then roll out to other areas later.</p> <p>1 General Practice clinic engaged in each of the areas with Community Health Service collaboration. Interview of practice staff involved in the program.</p>	<p>Training program delivered to Community Health Service staff and practice nurses involved in the program in areas of interest or need.</p> <p>Assessment of previous engagement in ActiveScripts activities. Survey of practice nurses knowledge of LifeScripts prior to intervention. Number of patients presented with LifeScripts.</p> <p>Survey of referral sites to assess continued use by patients.</p>

Objective 3

To increase use of under-utilized community facilities for physically active recreation purposes with partners in the industry.

Target groups

PCPs, agencies, recreation providers, Shire Councils.

Impact

Coordinated group of partners formed to action increased use of facilities by end of 2006.

System in place for actioning use of facilities using all possible partners by June 2007.

Link with Active Community Environments Network established at its development.

By June 2007 agencies able to direct users to facilities and equipment.

Strategies	Rationale	Reach	Evaluation
1. Support the development of a partnership between community health agencies, recreation providers and local government to audit the facilities available in the South Coast community. To provide a printed resource of the facilities.	Lack of knowledge what facilities are available on broad scale. At an agency level, knowledge of the local area and needs of local communities is already available and community connections well established. A database of facilities will allow best use of facilities on a shared basis and will provide a strong base for the LifeScripts physical activity component of this plan.	40 x facilities listed 1 x facilities register	Information for the register sourced from established PCP partners. Minutes and email records of ongoing communication between Active Communities Network, Rural Access Workers, Community Health Services and PCP HPOfficer. Interviews with Practice Nurses or GPs engaged in the LifeScripts program. Distribution record of the register.
2. Establish partnership between disability services and recreation centres to improve access to and patronage by people who could	Geelong leisure centres access project. msscott@geelongcity.vic.gov.au A partnership between Rural Access Workers and recreation providers.	4 x recreation centres – to be identified as areas of need or smaller populations e.g. Foster or Yarram and YMCA in Bass Coast. 2 x Shire Councils, 1 x Rural Access Worker, 1 x AAA worker, 1 x Gippsport, 2 x Moonya, South Gippsland Specialist	Pre, post survey of recreation centre membership. Established communication process between recreation centres managers/workers, workers in disability and

<p>have difficulty accessing facilities. (BCCHS, YMCA, SGH, Hardwork Café)</p>		<p>School. 30 x community members. Details of the project will be based on local need and reflect local recreation providers. 10% increase people identified as target group regularly accessing recreation centres. Target groups will be varied depending of the needs of each community as identified by local Community Health Service Health Promotion Officers: SGH, YDHS, BCCHS.</p>	<p>Community Health Services. Evaluation detailed in Community Health Service work-plans.</p>
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4.3 Leadership

Objective 4

To extend the understanding and skills of the processed for catchment planning and evaluation for health promotion in all agency staff by 2009.

Target

Agency staff and management.

Impact

PCP organisations indicate an increased understanding of the processes of catchment planning and evaluation and its relation to agency planning in an annual assessment and review of processes.

Joint planning and evaluation events occur biannually to support collaborative objectives between PCP partners over each year of the plan.

Evidence of new partnerships in health promotion present.

Strategies	Rationale	Reach	Evaluation
1. To continue the catchment process developed over 05 – 06 via workshops as identified by group members on planning and evaluation of Integrated Health Promotion Plans.	Potential for further partnerships present. Satisfaction with the 05 – 06 processes by member agencies. Continued contributions to Health Promotion Working Group.	All PCP agencies with aligned priority areas.	VicHealth Partnership Tool Pre plan survey of PCP agencies to identify ongoing needs in planning and evaluation skills with 6 monthly reviews. Individual workshops will include evaluation surveys..

4.4 Workforce development

Objective 5

To extend the understanding of integrated health promotion and its aims in all agency staff by 2009.

Target

Agency staff and management.

Impact

A system of training incorporated into health promotion plans of community health services.

All new agency staff at each community health service provided with health promotion information.

Of staff participating 90% report increased awareness of the principles of health promotion and how they could apply to their service.

Of the staff participating 50% report increased awareness of how to incorporate health promotion into their work.

Health Promotion education and information incorporated into staff orientation packages / training.

Strategies	Rationale	Reach	Evaluation
1. Training workshops provided to PCP agencies.	Swinburne Institute train the trainer model available and evaluated / local staff qualified to deliver training	2 courses delivered per annum	Training timetable available. Pre/post training evaluation. Member agency plans identify training provision to staff. Referral to training from variety of agencies.
2. Health promotion information booklet / brochure sourced for all community health and hospital staff as a quick reference guide. Presented to staff as part of brief training or new staff orientation package.	Integrated Health Promotion resource kit too detailed. Brochure, information sheet required.	Information presented with orientation of new staff in two Shire Councils, 5 community and women's health agencies and 2 other PCP agencies.	3 question phone survey of new staff positive.
			TOTAL BUDGET physical activity \$ 24,493

Priority goal: Access to Healthy and Affordable Food

4.2 Partnerships

Objective 6

To identify the physical, social, economic and cultural barriers to accessing and affording healthy food in the PCP catchment by June 2007.

Strategies	Evidence / Rationale	Reach	Evaluation
1. Link to the statewide food security network.	Well established body with extensive experience	Attendance at network activities	Attendance record.
2. Undertake food access mapping of the physical barriers on sample towns with high SEIFA scores.	Food access mapping Deakin Uni, Cate Burns studies for both rural and urban settings. Bass Coast Agricultural Audit. Deakin Anna Temperio GIS data mapping for food access.	2 sample towns.	Report available.

4.3 Leadership

Objective 7

To resource member agencies and local organisations with local, up-to-date information on barriers to accessing healthy and affordable food in the PCP catchment which will, in turn allow planning for local needs by June 2007

Target groups

Member agencies and local organisations.

Impacts

By June 2007 barriers to making healthy dietary choices identified.

Barriers prioritised into those most relevant for the PCP.

Target groups identified.

Tools currently available identified and some trialled.

Issues surrounding money, the food market, rural town planning and transport will be identified.

Towns/areas of greatest need identified.

Strategies	Rationale	Reach	Evaluation
1. Review interventions for socio-economic barriers to food.	Current interventions unknown in detail.	5 x databases accessed 15 x sample interventions identified	Report of interventions including annotated bibliography available.

Objective 8

To increase application of knowledge relating to healthy food to those people accessing community services by June 2009.

Target groups

Recipients of community services.

Impact

Attendance register at food groups / initiatives indicates membership majority health care card holders or referrals from other organisations providing community welfare services.

Referral systems in place from community services to food related groups by June 2007.
 Groups providing health and nutrition knowledge established with regular attendance by members of target group.
 Participants in interventions report increase in knowledge of healthy eating by end of each program.

Strategies	Rationale	Reach	Evaluation
1. Support the establishment of sustainable interventions to support community connection and knowledge of healthy eating at agency level.	Identify suitable sustainable interventions from food security forum. Community gardens in schools and older persons office of housing successful in South Gippsland Community kitchens support social interaction more than health knowledge; however is an avenue for health knowledge.	6 x community kitchens. 5 x community gardens. 5 x other cooking programs. 5 x primary school canteens. 3 x secondary school canteens.	Standard pre and post intervention survey established by PCP and circulated to all groups / initiatives. Results collated and reported to PCP.

4.4 Workforce development

Objective 6

To identify the physical, social, economic and cultural barriers to accessing and affording healthy food in the PCP catchment by June 2007.

Target groups

Target groups will be identified through the process.

Impacts

By June 2007 barriers to making healthy dietary choices identified.

Barriers prioritised into those most relevant for the PCP.

Target groups identified.

Tools currently available identified and some trialled.

Issues surrounding money, the food market, rural town planning and transport will be identified.

Towns/areas of greatest need identified.

Strategies	Evidence / Rationale	Reach	Evaluation
3. To conduct a forum to identify issues relating to access to healthy and affordable food in the South Coast area.	Identified in last CHP.	Health services, Shire Councils, food retailers and wholesalers, welfare agencies, church groups, transport services, trucking companies, Chamber of Commerce representatives, Town Progress Association representatives.	Attendance at forum from variety of agencies / organisations, individuals and community members. Action and plans outlined. Follow-up plans in place to forward promised actions in 6 months.

Objective 8

To increase application of knowledge relating to healthy food to those people accessing community services by June 2009.

Strategies	Evidence / Rationale	Reach	Evaluation
2. Build capacity of existing deliverers of health knowledge through group training opportunities.	Existing providers of health information. <ul style="list-style-type: none"> • YDHS – nutrition talks for groups in Yarram, Well for Life • SNAP – nutrition information for psych / disability rehab clients • BCCHS – nutrition talks to local community groups • GSHS – men’s cooking – cooking for 1, Melbourne Markets to schools • BCRH – rehabilitation groups, healthy hearts • SGH – healthy hearts, PALS, Well For Life • Salvation Army – living skills program • Milpara community house – budgeting, life-skills • Davey House • Kilmany UnitingCare – Family day care providers • Hard Work Café gym – healthy lifestyles program • General Practice Alliance – South Gippsland – Mind, Body Life Clinics • GPs – Eating Disorders Support Group. • PCP Nuts on Nutrition 	Training delivered twice a year x 3 years. 10 x agencies with staff attending.	Pre-training assessment of needs to relevant staff. Pre and post training questionnaire. Relevant staff attend training.
			TOTAL BUDGET FOOD \$20,300

Priority goal: Mental Health and Wellbeing

4.2 Partnerships

Objective 9

To build capacity of organisations in the South Coast Health Services Consortium catchment to address mental health promotion and social inclusion through interventions by June 2009.

Population Target Groups

PCP members and other organisations.

Impact

Partnerships developed between community and health, recreation and welfare agencies.

Socially and culturally isolated communities identified.

VicHealth Framework implemented on a variety of activities.

Mental Health promotion incorporated into the work of 8 PCP agencies.

Strategies	Evidence / Rationale	Reach	Evaluation
1. Support individuals and agencies to work together to deliver a community festival supporting social inclusion.	VicHealth.	See VicHealth Application	VicHealth evaluation requirements.
2. Continue support to the Mental Health Provider's Forum.	Mental Health providers linking with health promotion activities across catchment.	15 people per meeting x 6 per year.	Checklist 1 Hawe, King (2000).
3. Finalise links with Latrobe Regional Health Mental Health and Primary Mental Health Team.	Processes in place.	Organisations linked and working together.	Shared activities established and in place.

4.3 Leadership

Objective 10

To analyse the pre-existing data highlighting social inequity in the South Coast area in relation to physical activity, nutrition and mental health and distribute to PCP member agencies and broader partners by June 2007.

Target group

Socially disadvantaged.

Impact

Areas of social disadvantage identified and may include those socially isolated, new arrivals, refugees, older people, youth or geographic areas.

Report available by end 2007 to organisations on which to build further work relating to physical activity, nutrition and mental well being for those socially disadvantaged.

Those under-represented in service usage identified and why access is not occurring identified.

Strategies	Evidence / Rationale	Reach	Evaluation
1. Collect local data via existing reports including socio-economic data including the identification of disadvantaged groups and individuals in the area.	Evidence is out there but it is unknown and uncollated. Homeless youth Wellington study – Prue Stone High risk adolescent referral system records.	Data accessed from all identifiable sources and distributed to all member agencies and broader partners.	Report available on process and results. Data access available on PCP website and in print as requested.

4.4 Workforce development

Objective 11

To build capacity of organisations in the South Coast Health Services Consortium catchment to address mental health promotion and social support through interventions by June 2009.

Population Target Groups

PCP members and other organisations.

Impact

VicHealth Framework implemented on a variety of activities.
Mental health promotion incorporated into the work of 8 PCP agencies.

Strategies	Evidence / Rationale	Reach	Evaluation
4. Support continued delivery of Mental Health First Aid training or GAP training in the local area.	Courses conducted and well attended in area in 2004, 2005. Waiting list for further courses.	5 x courses delivered.	Course evaluation.
			TOTAL BUDGET MH \$18,260

4.5 Resources – PCP IHP Catchment Resource Summary

Estimated Integrated Health Promotion (IHP) PCP resource allocation

Table 2 – Estimated IHP PCP budget resource allocation

Capacity building components	PCP IHP Funding/Resources	
	\$ including carry over from 2004 / 06	Health promotion staff time
Partnership Development	24,493	10,000
Leadership	20,300	10,000
Organisational development		3,000
Planning for evaluation & Dissemination	Included in objectives under other area	4,000
Workforce development	18,260	3,000
Total PCP Resource/Budget Allocation	\$63,053	\$31,748

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

Table 3

Funding source/project	Links to Catchment Priority	Funding
Seniors Go for your life – Active Plus	Environments for physical activity Mental health and social inclusion	Pro-rata on 20,000 to April 2007 as per work plan.
Foothold on Safety – Upright and Independent	Environments for physical activity	Pro-rata on funding to June 2007 as per work plan.
VicHealth Community Festivals – Gung Ho, Working together	Mental health and social inclusion	\$10,000
TOTALS		Exact totals are unavailable but can be referenced at the various work plans for each project.

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 priority?

The PCP catchment planning process as adopted for the development of this plan allows for regular workshops addressing aspects of planning. Evaluation processes and methods are part of this larger process and will continue to be implemented annually. Each community and women's health agency of the South Coast Health Services Consortium will be reporting on their health promotion activities at the health promotion meetings held every two months. By attending the meetings and receiving minutes these agencies will be able to keep up to date on progress in other plans.

In line with planning processes adopted in the past and in the development of this plan, the SCHSC will provide the opportunity for member agencies to contribute the details of their integrated health promotion plans to a combined matrix including evaluation methods to be adopted. A health promotion matrix will request information from agencies describing indicators, actions and impacts of each of the member agency strategies. The PCP will collate this information and distribute it in a table format to its membership.

A bi-annual review of the health promotion matrix for the area will now include evaluation methods and will indicate progress towards interventions and will provide a summary of activity in the area for each priority. Further opportunity to link projects under the priorities of access to healthy and affordable food and environments for physical activity will occur through additional groups to be developed under the capacity building components of the above Community Health Plan.

Under each priority as described above a reference to each member agency with actions directly linked to the objective will be provided. This is indicated on the table provided for each strategy where this occurs as strategy level or under each objective where the agency strategy is different from that in the community health plan. These links will be electronically hyper-linked to the relevant section of each PCP member agency plan. As described Objective 4 / strategy 1 above, the PCP will also facilitate the evaluation process for member agencies and the PCP by developing tools which can be used over a variety of interventions under Objective 8 / strategy 2 above.

What processes will the PCP use to obtain an evaluation of the work around this priority across the whole PCP catchment?

Using the catchment planning processes put in place for the development of this plan, the PCP will continue to provide opportunities for workshops where member agencies will be able to provide feedback to the PCP on the overall capacity building activities outlined in the plan. Each May the PCP will consult with member agencies to identify any further support previously unidentified or addressed. In May 2007 this consultation will include planning to establish PCP capacity building activities which require the collection of information and data in the first year of the plan.

As part of the regular catchment planning workshop process as described, each priority area will be discussed individually. During this process the objectives and strategies within each priority area for both the catchment plan and member agency plans will be identified and discussed and evaluation methods identified. Agencies will be provided with checklist / tools to assist in evaluation of projects and in order that member agencies are better able to provide similar indicators to the PCP to ensure comparative measures between interventions across the catchment can be collected. A method which will allow the agencies to forward evaluation reports to the PCP in a similar form as that supplied to DHS will be established to ensure a collation of objective, strategies and evaluations under each shared priority area is made every 12 months.

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 South Coast Health Services Consortium will develop a detailed, combined evaluation plan to track the interventions of the member agencies. The tools to be used are a combination of the VicHealth Partnership tool and a variety of the checklists described in Hawe, King, Noort, Jorderns and Lloyd (2000) *Indicators to help with capacity building in health promotion*. NSW Health Department, Sydney.

How will the PCP know when the capacity building objective(s) have been achieved?

Each capacity building objective has reach and evaluation methods listed in the table provided under each objective in this plan. Further to this a full evaluation summary will be developed on completion of the member agency plans which will allow for capacity building to relate to agency plans where appropriate and as part of a larger matrix of the activities in the SCHSC area. Following this method the PCP will be in a position to monitor their own capacity building work and also keep abreast of the progress of agencies. The feedback of need from the agencies will inform any changes for the second and third years of the PCP plan.

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

The collection of plans in a combined matrix as described above in section 5.1 allows the PCP to provide opportunities to combine findings across the catchment and collate into papers and reports which describe the health promotion activities in the area. Member agency reports will complement this with more detail via linkages developed in the matrix. A role of the PCP as written in to this plan is to collect information and distribute it to the PCP membership, the Department of Human Services and broader community via reports, presentations and articles submitted to newsletters and journals.

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

The focus in this catchment on environments for physical activity, environments for physical activity and mental health and wellbeing all adopt a socio-ecological approach to interventions. 'To achieve population change multilevel interventions targeting individuals, social environments, physical environments and policies must be implemented to achieve population change'⁶ This health promotion plan and those of the member agencies focus on multilevel interventions which not only target screening and individual assessment but also include contribution to groups which will contribute to policy change.

The SCHSC and member agencies planning for health promotion have all identified interventions which address provide interventions which influence the social environments of their areas. A lack of social inclusion greatly influences health and well being and through interventions focusing on improving social inclusion and mental wellbeing member agencies and the SCHSC are contributing to increased support for better health. 'Many Victorians face a daily challenge of getting enough nutritious food to maintain their health. This challenge impacts on people's physical, mental and social wellbeing.'⁷

Interventions targeting environments for physical activity and accessing healthy and affordable food assist in developing environments which enhance health and provide affordances for better lifestyles for those with chronic disease. Growing evidence shows that the built environment can harm people's health if it causes barriers to physical activity and access to nutritious food. Diabetes mellitus is influenced by obesity, overweight and physical activity. In turn an increase in physical activity and health eating can contribute to a reduced chance of developing Diabetes mellitus. It therefore follows that health promotion interventions focusing on physical activity and health eating will contribute to reduced chances for developing Diabetes mellitus.

As can be seen in the member agency integrated health promotion plans many of the interventions are 'upstream' in their nature and often focus on the whole person or whole community support. Many member agencies engage screening staff in programs to increase their knowledge of the principles of health promotion and how they can be incorporated into direct care.

⁶ Sallis J, Cerbero B, Ascher W, Henderson K, Kraft K, Kerr J (2006) *An Ecological Approach to Creating Active Living Communities* Annu Rev. Public Health 27: 297-322

⁷ Dr Rob Moodie (2006) *VicHealth, Healthy Eating Information Pack* www.vichealth.vic.gov.au



Community Health Plan 2006 - 2009

Deliverable 3: Service Coordination

This deliverable has been developed at a regional level and represents an agreed view from Gippsland PCP's. In addition the deliverable builds on and extends the work of the former Better Health Care in Gippsland project

To improve the quality of care and quality of life of people living in Gippsland through a coordinated, collaborative region wide approach to service coordination.

To strengthen the capacity of the Gippsland health care providers to further the coordinated regional approach to Service coordination.

Goal	Objective	Strategy	Planned Impact
<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>Progress BATS framework across the region.</p> <p>Maintain regional standards and protocols for Service Coordination.</p>	<p>Satisfactory completion of the Service Coordination element of the Community Health Plan.</p> <p>Service Coordination Audit completed including annual reviews of Gippsland PPS Manual.</p> <p>Provide ongoing training as required on the regional standards and protocols.</p> <p>Maintain the BHCiG webpage on the GHA website to ensure only current standards are available.</p> <p>Establish a process for monitoring implementation of Service Coordination standards.</p>	<p>Increase in the number of agencies / programs signatories to Gippsland PPS Practice Manual.</p> <p>Gippsland PPS manual updated to reflect changes resulting from annual reviews and Service Coordination Audit.</p> <p>Gippsland PCP Service Coordination training plan developed, implemented and evaluated annually.</p> <p>Gippsland PCP SC Manual updates available on GHA website.</p> <p>Increase in number of agencies / program using e-referral platform as identified in audit.</p> <p>Increase in number of agencies using agreed processes and standards as identified in Service Coordination Audit.</p>

<p>2. 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>Strengthen links with General Practice Alliance – South Gippsland.</p> <p>Increase GP involvement in care planning.</p>	<p>Establish Regional Service Coordination Working Group, including representation of GP Divisions.</p> <p>Develop and implement GP Service Coordination Engagement Strategy project including communication strategy, e-referral, PKI, care plans and improved discharge planning processes.</p>	<p>Annual increase in number of Chronic Disease Management Plans (MBS item 723).</p> <p>By December 2007 every Gippsland hospital electronically notifies GPs and other community based agencies when one of their patients is admitted to hospital.</p> <p>By June 2009 80% of GP practices have PKI certificates and can receive encrypted email messages about their clients.</p>
<p>3. Successful implementation of the Victorian Service Coordination Practice Manual and subsequent versions of the Service Coordination Tool Templates.</p>	<p>Progress statewide Service Coordination standards and tools across the region.</p>	<p>Victorian Service Coordination Practice Manual Training Plan developed and evaluated-</p> <p>Review Gippsland PPS Manual standards following the completion of the Statewide Service Coordination Manual.</p>	<p>Increased level of knowledge by health service staff of the Victorian Service Coordination Practice Manual.</p> <p>Gippsland PPS manual updates reflect Victorian Service Coordination Practice Manual.</p>

<p>4. Change management support for implementation of e-referral.</p>	<p>Roll out e-referral across Gippsland.</p>	<p>Gippsland PCPs, Divisions of General Practice and member agencies actively participate in Regional Gippsland Infoxchange PAG and PCP PAG's.</p> <p>Gippsland agencies develop and implement agency e-referral implementation plans.</p> <p>Gippsland PCPs develop support strategy for agencies to develop e-referral implementation strategies.</p>	<p>Annual increase in the number of e-referrals sent.</p> <p>By June 2008 all Gippsland health and welfare services use e-referral to manage their external agency referrals.</p> <p>By June 2009, 20% of General Practices use e-referral to make referrals to state funded health and welfare services.</p>
<p>5. Improved amount and accuracy of information to support referral.</p>	<p>Build up e-referral information.</p>	<p>Gippsland PCPs support agency updating of GHA and Infoxchange service information systems.</p>	<p>Annual increase in the number of agencies service information listed on the Statewide Human Services Directory.</p>



Community Health Plan 2006-2009

Deliverable 4: Integrated Chronic Disease Management

This deliverable has been developed at a regional level and represents an agreed view from Gippsland PCP's. In addition the deliverable builds on and extends the work of the former Better Health Care in Gippsland project

To improve the quality of care and quality of life of people living in Gippsland through a coordinated, collaborative region wide approach to integrated chronic disease management.

To strengthen the capacity of the Gippsland health care providers to further the coordinated regional approach to service coordination and extend the roll out of the Chronic Disease Management Model.

All PCPs

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.	Identify gaps in relation to self-management.	Satisfactory completion of the Integrated Chronic Disease element of the Community Health Plan, which complies with DHS frameworks, and addresses identified ICDM foci. Self management mappings completed. Provide self-management training as required.	Gippsland PCP Training and education strategies reflect findings from self management audit. Increased level of evidence based self management education knowledge by health service staff.
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.	Roll out of Chronic Disease Management (CDM) strategy / .model across Gippsland.	Establish regional CDM Working Group. Develop BHCiG CDM Training Kit. Roll out and evaluate BHCiG CDM training. Support CDM model in local areas.	Increased level of staff knowledge and confidence in implementing CDM models. Increase in the number of member organisations that are actively involved in implementing integrated CDM models.

Goal	Objective	Strategy	Planned Impact
<p>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.</p>	<p>Incorporate BHCiG CDM Model into PPPS Manual and SC systems.</p>	<p>Inclusion of CDM model in the BHCiG PPPS which identifies the specific roles and responsibilities of organisations such as acute and community health services in the provision of self management interventions, and a process for determining the most suitable self management intervention for clients, including where and by whom the intervention is best delivered.</p> <p>Inclusion of content relating to integrated chronic disease management in PPPS, including cross disciplinary/multi organisation, (including GP) care planning (annual).</p>	<p>Gippsland PPPS Manual updated to incorporate CDM model.</p>

Goal	Objective	Strategy	Planned Impact
<p>4. Developed and defined local agreements and systems to identify clients with chronic disease who require comprehensive assessment, or cross-disciplinary/multi-agency (including GP) care planning by working with PCP member agencies, particularly GPs.</p>	<p>Adoption of Chronic Care Model by GHSP, PCP's and Divisions of General Practice as the basis for work to improve chronic disease management.</p> <p>The development of more formal partnerships between PCP's and Divisions of General Practice including the agreement to roles and responsibilities of GP Divisions and PCP staff in relation to each of the Chronic Care Model components.</p>	<p>Establishment of local CDM Working Group.</p> <p>Gippsland Divisions of General Practice and Primary Care Partnerships develop a Regional Chronic Disease Management training calendar for 2006-09 based on key components of the Chronic Care Model and this plan is jointly implemented by July 2009.</p> <p>Implement GP engagement project.</p>	<p>20% of all Gippsland GP Practices have active membership in a CDM local cluster/ project by July 2009.</p> <p>All Gippsland Primary Care Partnerships and Divisions of General Practice jointly develop local catchment Chronic Care Model implementation work plans based on BHCiG Chronic Disease Management Resource Kit by December 2007.</p>
<p>5. Strengthened approaches to address disadvantage and health equality in Integrated Health Promotion initiatives, including barriers to participation such as chronic disease.</p>	<p>Gippsland PCP CDM strategies include focus on addressing health inequality barriers to CDM.</p>	<p>Gippsland CDM education and training strategy includes modules on health inequality barriers.</p>	<p>Increase in staff knowledge of addressing health inequality barriers to CDM.</p> <p>Local CDM projects include strategies addressing health inequality barriers to CDM.</p>

NOT APPLICABLE TO SCHSC.

PCPs working with CHSs funded under the EIICD initiative

Goal	Objective	Strategy	Planned Impact	Actual Impact	Comments
6. Successful implementation of workforce development strategies for self-management, particularly for community health services and GPs.					
7. Successful implementation of communication and marketing strategies (developed in conjunction with the Divisions of General Practice) that promote the benefits and availability of local self-management interventions to GPs.					
8. Improved communication and collaborative care planning (by working closely with the Divisions of General Practice) between GPs and community health services.					
9. Development and adoption of disease-specific care pathways to ensure that clients get the right care in the right place, regardless of where they enter the service system.					

Goal	Objective	Strategy	Planned Impact	Actual Impact	Comments
10. Support for change management provided to agencies, particularly community health services, which are implementing new systems or strengthening existing systems to provide proactive care rather than reactive care for clients with chronic disease.					
11. Facilitation of a process for agencies to develop and implement consistent approaches to the use of decision support tools to support ICDM.					
12. Dissemination of transferable change management lessons in relation to ICDM.					
13. Completion of the statewide evaluation tools for EIICD.					