

**Wellington**

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Wellington Primary Care Partnership

Community Health Plan 2006 - 2009

**Endorsed by PCP Chair:**

Name: Diane Wilkinson

Signature:

Date:

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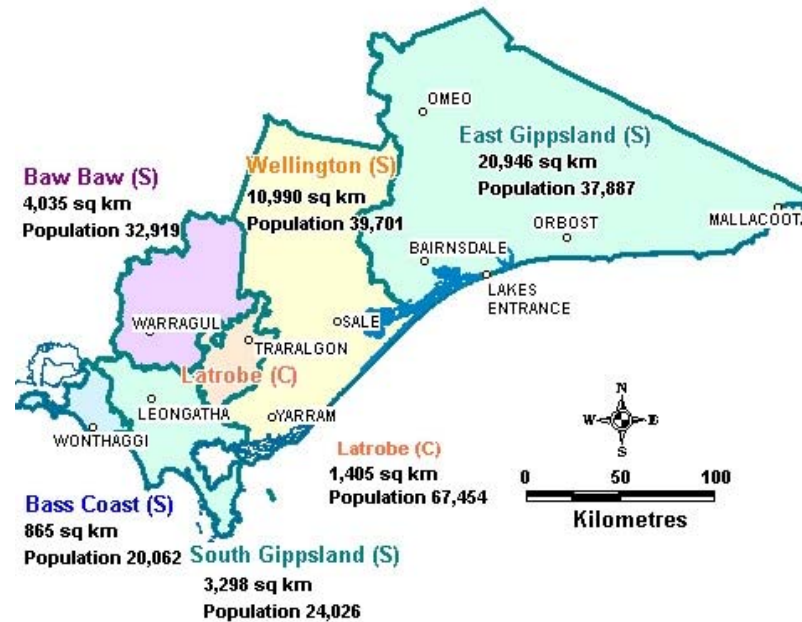
# The Wellington Primary Care Partnership

The Wellington Primary Care Partnership is a voluntary partnership of 24 health and community based agencies in the Wellington Shire.

## Our Vision is that:

*'Together we will enhance health opportunities and outcomes for the communities of Wellington.'*

Wellington PCP's overall vision emphasises collaboration and partnership. It is our vision to bring together all people, health professionals, agency staff and community members in Wellington, to share the goal of improving health opportunities and outcomes for all.



The Wellington Community Health Plan 2006 – 2009 describes the direction of the work of the Wellington Primary Care Partnership for the next three years. This plan will build on the achievements of the previous Community Health Plan and will support the four deliverables of the PCP Strategy for 2006 – 2009.

- Partnership development
- Integrated health promotion
- Service co-ordination
- Integrated chronic disease management

The planning direction of each of these four deliverable areas reflects Primary Care Partnership's increased focus on change management and capacity building. Sustainable health outcomes are the result of shared planning, strong partnerships and commitment. Actions, therefore, are concerned with systems change, policy development and evidence based information about which population based programs work most effectively.

There are four key action areas for building capacity in each deliverable of the plan. They are:

- Partnerships: working collaboratively, sharing vision and strategic planning
- Leadership: role modelling and building skills which motivate organisations and offer them opportunities to grow
- Organisational Development: strengthening organisational support by strengthening organisational policies, planning, structures and resources.
- Workforce Development: development of skills and knowledge of the workforce within organisations

## Deliverable 1: Partnership

### 1. 1 Partnership vision

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

***‘Together we will enhance health opportunities and outcomes for the communities of Wellington’***

Wellington PCP’s overall vision highlights the desire for working together. It is our vision to bring together all people, health professionals, agency staff and community members in Wellington, to share the same goal of improving health opportunities and outcomes for all.

Planning in partnership makes for effective resource use, more focussed target groups, greater reach, more extensive expertise and ownership, a stronger evidence base, more community involvement and a greater likelihood of identifying community needs and inequity.

Implementing the plan in partnership means a broader mix of interventions, a multi-faceted, strategic approach, shared information and a greater likelihood of achieving goals.

Evaluating in partnership means enhanced communication and reflection, shared learning, improved direction and respectful relationships between agencies built on trust.

By 2009 Wellington Primary Care Partnership will have stronger, more effective partnerships and networks, a more collaborative approach to improving health outcomes in the catchment and a broader partnership base.

## **1.2. Achieving the vision: *priority setting and problem definition***

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

- To increase the Wellington PCP membership base to include a broader range of agencies
- To increase partner involvement in integrated strategic planning.
- To engage organisations that have yet to embrace the PCP strategy
- To strengthen relationships between member agencies
- To ensure that partners have the necessary skills for collaborative planning and implementation.
- To promote the culture of the Wellington PCP as one based on trust and respect.
- To more effectively evaluate our work and be accountable to member agencies and the community.
- To promote the PCP strategy across the catchment.
- To shift the focus of Wellington PCP to capacity building and change management.

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

### Organisational Development

Goal	Objective	Strategies/Interventions	Estimated Impact
Develop robust and flexible partnerships with diverse memberships that are able to effectively pursue collaborative opportunities and also enable an integrated response to local needs	<p>By December 2009 the WPCP will have increased its active membership by 10% each year over the three years of the plan.</p> <p>During the life of the plan the WPCP will establish and build on existing partnerships with key networks and organisations across Wellington</p>	<p>Review WPCP structure and processes to ensure that the needs of agencies are met and that communication between agencies is maximised.</p> <p>Potential new members are actively approached .</p> <p>Research and discuss potential opportunities for new partnership opportunities with agencies on a regular basis.</p> <p>Links with networks like <i>Wellington Working Together</i> are strengthened through shared vision and planning.</p> <p>Support other projects and networks where relevant</p>	<p>Increased attendance at meetings.</p> <p>10% increase in active membership.</p> <p>Member agencies report improved relationships and benefits from membership.</p> <p>Opportunities for collaborative agency project work are increased.</p>
	<p>During the life of the plan community input into the identification of local needs is supported, encouraged and specifically planned for.</p>	<p>Community participation strategies as outlined in this plan are devised and implemented within agencies and supported by WPCP.</p>	<p>Agencies include community participation in their project plans and evaluation processes.</p> <p>Agencies report increased community participation in project work and in other capacities.</p>

## Partnership

Goal	Objective	Strategies/Interventions	Estimated Impact
Adopt a quality improvement approach to assess partnership strengths and weaknesses and act on this information to progress the partnership	<p>To improve the quality and effectiveness of existing partnerships communication mechanisms/processes will be continually reviewed during the life of the plan.</p> <p>During the life of the plan accountability of WPCP work will be more transparent to member agencies and the Wellington Community.</p>	<p>Partnership effectiveness is assessed on a regular basis using an appropriate partnership assessment tool.</p> <p>Discussion of communication procedures is a regular part of WPCP meetings</p> <p>Opportunities are created for partnership feedback.</p>	<p>Strengths and weaknesses are acknowledged.</p> <p>Weaknesses are addressed in future planning.</p> <p>Partnership effectiveness is assessed annually.</p> <p>Agencies report improved accountability and more open discussion about WPCP operations.</p>
Develop greater engagement and active participation in PCP processes and activities with relevant stakeholders, in particular acute health services and Divisions of General Practice	During the life of the plan WPCP will actively research and facilitate opportunities for collaborative work with EGDGP.	<p>The possibility of projects which might engage new members is continually investigated.</p> <p>GPs and other members from the acute sector are actively sought as partners in relevant project work.</p> <p>Individual dialogue with the East Gippsland Division of General Practice regarding their individual capacity building needs as an organisation is a regular occurrence</p> <p>WPCP agency achievements are promoted amongst agencies</p> <p>WPCP to support projects, like Falls Prevention and HALS, to increase engagement of the acute sector.</p> <p>WPCP to strengthen the work of the <i>Wellington Working Together</i> Partnership in its focus on the health and well being of children.</p>	<p>Increased participation from GPs in strategic planning and project work.</p> <p>Increased communication between the EGDGP and WPCP agency members.</p> <p>Increased attendance of EGDGP representatives at WPCP meetings</p> <p><i>Wellington Working Together</i> acknowledges WPCP support and contribution.</p>

## Leadership

Goal	Objective	Strategies/Interventions	Estimated Impact
Facilitate change management through supporting leadership and capacity building within member organisations	<p>During the life of the plan PCP member agencies and individual workers are supported and provided with opportunities to take on Leadership roles within WPCP networks.</p> <p>Agencies are encouraged and supported to take on new project work in the role of Lead Agency or as a key partner.</p>	<p>Agencies are supported in submission writing for new projects</p> <p>WPCP staff keep the community and key agencies informed about current evidence based strategies in health promotion and public health information.</p> <p>Raise awareness in the Wellington community of the role and achievements of the Wellington Primary Care Partnership</p> <p>Assess the need for WPCP support or orientation for new "Lead agencies", eg Is there a need for a Guidelines document to be created?</p>	<p>Increased participation from agencies at leadership level in steering committees working parties etc.</p> <p>The number of different agencies involved in leadership roles in PCP projects is increased by 10%</p> <p>Agencies report feeling supported in new roles</p>

## Workforce Development

Goal	Objective	Strategies/Interventions	Estimated Impact
Increase opportunities for agency staff to participate more fully in WPCP planning and evaluation activities.	During the life of the plan individual agency staff will improve their understanding of the PCP strategy generally and how agencies and individuals can be supported through PCP involvement.	Agencies are supported in the identification of training needs of staff/organisations and ways in which PCP input can assist to upskill in these areas.	Training opportunities are identified and made available.  Agency staff report improved skill level in nominated areas.
	During the life of the plan agency staff will improve their knowledge and understanding of health promotion principles and the Social Model of Health.	Develop a plan for meeting the needs of individual agencies with regard to workforce development to increase participation levels.	Plan is implemented and evaluated
	Based on recommendations from the May 29 Community Participation Forum and further consultation with members, the WPCP will develop and implement a capacity building strategy to support members in improving community consultation practice in individual agencies.	<p>WPCP will research “Best Practice” examples of successful community consultation projects highlighting processes, contexts and evaluation procedures used during these project</p> <p>WPCP will research current information/research on community consultation and pass it on to member agencies.</p> <p>WPCP will support agencies in developing evaluation tools or surveys to be used during community consultation processes. Agencies with common core business could be supported in groups to develop shared tools for use during the consultation process.</p>	Community consultation processes are an accepted part of WPCP and agency planning, policy making and project implementation.

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

Wellington Primary Care Partnership is a voluntary partnership of (currently) 24 health and community based agencies working together to improve health outcomes of the people of Wellington. Our members are listed below.

There are two levels of voluntary membership.

### Level 1 (12 agencies)

- Full membership
- Receipt of all WPCP communications
- Participation in WPCP meetings (with full voting rights), consultative and planning processes and other activities, including joint projects.

### Level 2 (12 agencies)

- Receipt of all WPCP communications
- Optional attendance at meetings (without voting rights).

Agency name.	Type of membership	Deliverables involved in
Baptist Community Care ( BapCare)	Level 1	All
Central Gippsland Health Service	Level 1	All
Department of Veteran Affairs	Level 1	All
East Gippsland Division of General Practice	Level 1	All
Gippsland Women's Health Service	Level 1	Partnerships, IHP
GippSport	Level 1	Partnerships, IHP

Latrobe Community Health Service	Level 1	All
Latrobe Regional Hospital	Level 1	All
Ramahyuck District Aboriginal Corporation	Level 1	All
School Focused Youth Service	Level 1	Partnerships, IHP
Villa – Maria Sale	Level 1	All
Wellington Shire Council	Level 1	Partnerships, IHP
Anglicare	Level 2	All
MS Australia (NSW/Vic)	Level 2	Partnerships, IHP
SNAP Gippsland	Level 2	Partnerships, IHP
Wellington Special Needs Network Inc	Level 2	Partnerships, IHP
Yarram and District Health Service	Level 2	All
Dargo Bush Nursing Centre	Level 2	All
Eastern Gippsland Arts and Recreation Access Group	Level 2	IHP, Partnerships
Deaf Access Gippsland Victoria	Level 2	IHP, Partnerships
Sale Community Mental Health Service	Level 2	Partnerships
Mental Illness Fellowship Sale	Level 2	IHP, partnerships
Gippsland Centre Against Sexual Assault	Level 2	IHP, Partnerships
Vision Australia	Level 2	IHP, Partnerships
Department of Human Services	(non-member participant)	All
Department for Victorian Communities	(non-member participant)	All

## Deliverable 2: Integrated Health Promotion

### 2.1 IHP vision

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

This original overall vision for the Wellington Primary Care Partnership is the basis for all the work of the Wellington Primary Care Partnership

Over the next three years, the Wellington Primary Care Partnership will work towards building the capacity of both its member agencies and other organisations in the Wellington Community, to more effectively deliver health promotion programs to improve community health outcomes. The people of Wellington will have access to an environment which is supportive of a healthy active approach to living and as a community will have increased understanding and opportunity to be actively involved.

Organisations will have a greater awareness of broader health issues which directly affect their local community and a greater knowledge of the Social Model of Health and how the determinants of health can be addressed within Wellington. This increased understanding, together with a more collaborative approach to problem solving, could lead to increased impact on health inequities and improved health outcomes for all.

Wellington Primary Care Partnership is committed to building strong partnerships between agencies, both within the Primary Care Partnership and in the community at large, with a particular focus on community participation in planning, implementation and evaluation of health promotion work.

## 2.2 Priority Setting and Problem Definition

### Integrated Health Promotion Catchment Priorities.

The direction of the 2006 – 2009 Integrated Health Promotion work in the Community Health Plan is underpinned by a number of planning documents:

- Wellington Shire Council Municipal Health Plan ( called the Healthy Living Plan 2006 – 2009)
- Wellington Primary Care Partnership Community Health Plan ( 2004 – 2006)
- Victorian Population Health Survey
- DHS Community Data Sets
- National and State Health Priority areas
- Vic Health Burden of Disease Research
- A Fairer Victoria
- Gippsland online
- Wellington Working Together Action Plan 2006 - 2007

In particular the CHP is influenced by the Wellington Shire Council's Healthy Living Plan, which addresses the social determinants of health which are the social, economic, built and natural environments of Wellington communities. These determinants of health in turn influence the social, psychological and lifestyle factors of the people of Wellington. The Wellington Primary Care Partnership participated in the writing of the Healthy Living Plan and the Community Health Plan directly aligns with it.

The three priority areas for 2006-2009 in Wellington have been identified during a comprehensive strategic planning process. This process began in May 2006 with a whole day, planning with member agencies and an external facilitator. The decision was based on member agency preferences, evidence including local data and State and National policy, previous achievements of the WPCP, existing health promotion plans, projects already operational within Wellington and emerging issues within the Wellington Community identified by community input.

**The priority areas for the WPCP 2006 – 2009 Community Health Plan are:**

- Physical Activity and Active Communities
- Healthy Eating and Nutrition
- Mental Health and Well Being

These priorities are carried forward from the 2004 – 2006 Community Health Plan. Members of the Wellington Primary Care Partnership decided that work in these very important priority areas needed to continue, building on what has been already done and expanding some aspects of previous work. The WPCP's role will be to build the capacity of organisations to be more effective in working in these areas, through partnership strengthening and a consistent, collaborative approach.

**Goal Definition**

**Physical Activity and Active Communities**

**Goal: To increase the capacity of agencies in the Wellington catchment to offer programs and opportunities for participation of Seniors in active recreation.**

Economically, the disease resulting from inactivity is proving to be very costly – annual direct health care costs associated with cardio-vascular disease in 1994 were \$3,719 million (*VicHealth Burden of Disease*)

The human cost of inactivity is also extraordinarily high. Physical inactivity causes more than 8000 deaths annually, including 77,000 premature potential years of life lost. (*Be Active Australia: A Group Framework for Health Sector Action for Physical Activity 2005 – 2010*)

The Victorian Population Health Survey 2003 indicates that almost 32% of adults between 55 and 64 in Gippsland were insufficiently active for health benefits. This figure rose to nearly 51% for adults over the age of 65.

Given that research (*Gippsland Region Health, Wellbeing and Demographic Profile*) shows that Wellington will have a significantly higher number of older people than the Victorian average in the years 2001 – 2021, the health outcomes of inactivity in older people will be high on the region's health agenda.

By gathering and examining the local evidence and talking to the Wellington community, the barriers to lack of active participation can be identified and the broader determinants of health, relating to physical activity, such as recreational space, public transport, opportunities and opportunities to be active, can be linked to this information.

Wellington Primary Care Partnership will work closely with Wellington Shire Council to develop and implement the Shire's Positive Ageing Strategy across the catchment. Broad community consultation will inform both the Healthy Living and Community Health Plans as to direction and the identification of health inequities.

## **Nutrition and Healthy Eating**

**Goal: To improve communication and strengthen partnerships between agencies, schools and the general community to identify and more effectively address healthy eating issues in the Wellington Community.**

Almost 60,000 Australians in low income families go without meals or are food insecure. (*ABS 2002*) Obesity and overweight pose a major risk for chronic diseases including type II diabetes, cardiovascular disease, hypertension, stroke and certain forms of cancer. (*Vic health 2006*)

The key causes are increased consumption of energy dense foods high in saturated fats and sugars and reduced physical activity. (*Vic Health 2006*)

In Gippsland the Burden of Disease shows that the life expectancy of both males and females is below the Victorian average. The diseases that contributed most to the burden of disease in Gippsland were cardiovascular disease, cancer and mental illness.

Indigenous communities in Gippsland have a much lower life expectancy rate (median age at death for indigenous Australians was 40 for males and 51 for females in 2000). The main causes of Koori deaths in 2000 were heart disease and heart attacks, mental health issues and drug/alcohol related problems. Healthy eating issues play a

major part in cardiovascular disease. This highlights the importance of working with Ramahyuck in supporting Indigenous-focussed health promotion strategies.

The goal for Wellington PCP is therefore to work with the community and relevant agencies to develop a collaborative approach to the barriers to healthy eating. In particular there will be focus on bringing health professionals and schools together to develop some consistency in direction and to develop joint strategies to address the broader determinants of health, relating to nutrition and healthy eating

### **Mental Health and Wellbeing**

**Goal: To build the capacity of agencies to collaboratively plan a Wellington community approach to increasing awareness and knowledge of mental health issues and their implication locally.**

Mental and Behavioural Disorders constitute 13 per cent of the global burden of disease.

One in five Australians will experience some form of mental illness at some stage in their lifetime. (*VicHealth Burden of Disease 2001*) By 2020 depression alone will constitute one of the largest health problems worldwide.

The human, social and economic consequences of mental health disorders and illness are great. With mental illness becoming such a significant issue, there is a growing realisation that focussing only on treatment and rehabilitation has limitations and that finding ways of promoting good mental health and wellbeing must be part of the long term strategy. (*VicHealth Evidence –based Mental Health Promotion Resource. 2007*)

Wellington is not immune to the problems associated with poor mental health. In fact it is in the top 5 causes of disability in Wellington. The “VicHealth Evidence-based Mental Health Promotion Resource” provides the Wellington Community with an excellent framework for gathering local information around the three identified social determinants of mental health and wellbeing. This resource will guide the direction of the WPCPs strategies throughout the life of the next plan.

## **2.3 Solution generation (mix of interventions to be used by PCP member agencies)**

### **Physical Activity and Active Communities**

This priority is a continuation of work completed in the 2004 – 2006 Community Health Plan where the focus was on the successful completion of individual project work, promoting community participation in physical activity. The commitment from agencies to this priority, then, was clear and during the recent planning phase, where data from Wellington was revisited, there was again clear direction from agencies to continue integrated health promotion work in this area.

The focus for Wellington PCP is to build the capacity of member agencies to deliver effective integrated health promotion to Seniors in Wellington. The evidence about Wellington's ageing population and low activity levels is well documented. The connection between mental health and physical wellbeing is also well established. Mental health and wellbeing is an increasingly important issue for the Wellington community.

The emphasis on capacity building reflects the change in the way PCPs operate across the State and, on a more local level, it reflects increased knowledge, skill and confidence levels within agencies. With partnership, workforce and organisational support, agencies can become leaders, managers or partners involved in health promotion project work.

Currently agencies like the Department for Veteran Affairs (DVA) and Villa Maria are promoting increased activity levels in their organisations. The Healthy Active Living for Seniors and Whole Community Falls Prevention Projects are being implemented and involving the community in a variety of social marketing and consultation strategies. Both projects are increasing opportunities for participation by seniors. Wellington PCP has a commitment to resource and support strategy implementation of both these projects.

*Wellington Shire Council* has just engaged the more Senior members of the community in extensive consultation to inform the Positive Ageing Strategy. This strategy, relating to the four environments for health, identifies issues and opportunities for older people to improve their quality of life. Wellington PCP was involved in the consultation process and will work with Wellington Shire council to implement that strategy across the catchment. Wellington

Shire Council is also working on improving access to services and facilities for Seniors – an intervention supported in the Wellington Community Health Plan.

*Wellington Shire Council's Healthy Living Plan* outlines a variety of interventions including improving recreational space, footpaths and walking trails, building partnerships with other agencies and strengthening community and health networks which support their work. (available on Wellington Shire's Website)

*Yarram and District Health Service (YDHS)* aims to increase community knowledge about available facilities for recreational activity and to facilitate the use of these facilities. Interventions include targeting women on farms who experience isolation and looking at ways to improve their participation levels. The promotion of walking through *Walk and Talk* and *Pittstop Screening* through health promotion marketing and partnership work is an important part of Yarram's health promotion agenda. These interventions will promote increased activity for older members of the community. (please refer to Yarram and District Health Services Plan)

*Gippsport* offers general support for all kinds physical activity, promotion and events, having just completed a successful project, in conjunction with Gippsland Women's Health Service, setting up walking groups based at Wellington Neighbourhood Houses. This project will be extended, with support from Wellington PCP, to build the capacity of Neighbourhood Houses to train and lead walking groups, with a focus on the more senior members of the community.

### **Healthy Eating and Nutrition**

Wellington PCP member agencies have again prioritised Healthy Eating and Nutrition. It is a key issue for YDHS and Central Gippsland Community Health Service (CGHS), who have key objectives and strategies within their own organisations to address this priority area. The role of the Wellington PCP will be to identify key issues and key players, contribute to the evidence base to support their work and establish links with other relevant projects.

The Wellington PCP focus is on strengthening partnerships between health agencies and schools to better address eating and food access issues in Wellington Schools. Agencies felt that the health and lifestyle of our young people was crucial to the future health of the population. Given that recent school policy changes will support work done in schools and that many primary schools, in particular, are very keen to be involved, it seemed an opportune time

to use the momentum currently generated by *Kids Go For Your Life* to support schools and agencies to create a climate of healthy schools in Wellington. The current evidence supported this decision.

In the previous two years, *the Body Friendly Schools Project* was started by CGHS and for a number of reasons not completed. This project aimed to address nutrition and healthy eating in 5 primary schools in Wellington through resource provision and teacher support. Building on the current promotion work in schools by *Kids Go For Your Life*, CGHS would like to update this project and continue to roll it out in schools. CGHS is also currently coordinating the *Smiles for Miles Project* which links directly with healthy eating in schools. YDHS also aims to work with whole school community of Alberton Primary School, to establish a healthy eating policy.

Wellington PCP is currently a participant in the Wellington Working Together Partnership which has a focus on the welfare of children and families. Although the focus is not always on health promotion, there is some effective partnership strengthening with DEET staff occurring through this group. Strategic planning for children's health in Wellington is a part of the group's brief and is relevant to the WPCP's capacity building strategies for healthy eating and nutrition.

## **Mental Health and Well Being**

The evidence for the importance of mental health and well being as a priority area for integrated health promotion is overwhelming. There is growing recognition that some of the major determinants of our mental health and well being lie within the social and economic aspects of our lives. VicHealth defines three key determinants of mental health as social inclusion, freedom from discrimination and violence and access to economic resources.

During the planning process, the importance of mental health and well being was recognised and the links between physical health, healthy communities and mental well being were clear. This was a priority for Wellington PCP agencies. Commitment to work together on this far reaching issue was evident.

Over the previous two years, two small projects were planned in this area so many agencies have had very little experience with mental health promotion. The WPCP will take an educative role in ensuring that agencies understand the broader determinants of mental health and are aware of the evidence around mental health promotion.

A mapping exercise will be implemented to identify the issues for Wellington and to recognise the input of current local service deliverers. This will inform the mental health promotion work of agencies.

*Gippsland Women's Health Service (GWHS)* is a key player in health promotion addressing family violence issues. Wellington PCP will support the work of GWHS in increasing community awareness about the impact of family violence by adding to the local evidence base around this issue.

Yarram and District Health Service aim to promote awareness about mental health issues by addressing the social connectedness determinant. Yarram is an isolated community with a shortage of public transport which has an impact on social connectedness. YDHS has strategies to address local social connectedness issues and to raise the profile of mental health issues generally.

## 2.4 Capacity building

### Physical Activity and Active Communities

Priority goal: **To increase the capacity of organisations, in the Wellington catchment, to offer programs and opportunities for the participation of Seniors in organised active recreational activity by June 2009**

#### Organisational development

Objectives	Interventions	Impacts
By December 2008 the Wellington Shire Council's Positive Ageing Strategy and Healthy Living Plan and WPCP's Healthy Living for Seniors and Falls Prevention projects have at least 2 shared objectives, 2 shared strategies and shared evaluation processes.	<p>Contribute to evidence base to support effective physical activity strategies for Seniors</p> <p>Build partnerships with Wellington Shire Council through regular contact and communication</p> <p>Work with Wellington Shire Council in identifying and addressing barriers to participation in physical activity for seniors</p>	<p>Partnerships between WPCP members and WSC are enhanced</p> <p>Regular communication is established</p> <p>Barriers to participation are identified and discussed with member agencies including Wellington Shire Council</p> <p>Plans have shared processes and aims.</p>

## Partnership

Objectives	Interventions	Impacts
By June 2009 at least 60% of member agency evidence based physical activity strategies. outlined in plans, will have been implemented and evaluated.	Support Lead Agencies by researching evidence based health promotion strategies.	Falls prevention, HALS and other projects are completed within specified time period with at least 60% of impacts achieved  Lead Agencies report satisfaction with WPCP support
	Facilitate Steering Committee function through WPCP membership, resourcing and partnership building.  Make active approaches to potential links and partners for project work through WPCP membership and other networks.	Falls Prevention evaluation identifies work of the WPCP in building capacity for the project through partnership building  New partners/links within projects identified.
	Processes reviewing Falls Prevention/HALS partnerships are put into place and reviews are done on a regular basis.	Vic Health or other relevant partnership tool, used before and after project indicates an improvement in partnership strength.

## Leadership

Objectives	Interventions	Impacts
By June 2008 key agencies, will each have identified at least 2 strategies that address issues, currently limit access to participation by Seniors.	WPCP to support member agencies in identifying strategies to address access issues.  Research relevant evidence based strategies for agencies.	Areas of inequity of access are identified, discussed, and shared.  Strategies to address access issues are shared between agencies.

## Workforce development

Objectives	Interventions	Impacts
<p>By June 2007 at least 1 workforce development need for physical activity implementation per lead agency is identified</p> <p>By June 2009 lead agencies have implemented strategies to address workforce issues</p>	<p>WPCP provides significant educational input with regard to Health Promotion Practice and understanding of the social Model of Health</p> <p>WPCP to support key agencies in identification of workforce training needs.</p> <p>WPCP to resource and support strategy implementation</p>	<p>Agencies report increased skill level/knowledge in PA area.</p> <p>Agencies report improved knowledge of good Health Promotion practice and the Social Model of Health,</p> <p>Reported increased capacity of agencies to successfully implement physical activity projects for Seniors</p> <p>At least one agency workforce development need is addressed</p>

## Nutrition and Healthy Eating

Priority goal: **To improve communication and strengthen partnerships between schools, agencies and health professionals to better address healthy eating and food access issues in Wellington Schools.**

### Organisational development

Objectives	Interventions	Impacts
By Dec 2008 key agencies in Wellington will have planned an integrated healthy eating/food access strategy to support schools and agencies across Wellington.	Survey key partners to establish current commitment and practice. Facilitate processes to establish links between partners and agencies. Research evidence base for existing strategies in this area. Determine needs of the key agencies in terms of WPCP support for the planning/implementation of a joint strategy	Reported and demonstrated commitment to developing integrated strategy. Meetings held and minutes recorded Direction determined, recorded, and promoted to other agencies/schools etc. Relevant information passed on to agencies.
By December 2009 at least 5 key agencies in Wellington will be working together to implement this strategy.	Support <i>Kids Go For Your Life</i> and <i>Walking School Bus</i> projects through Steering Committee representation and promotion. Link with Wellington Working Together to establish links to strengthen PCP and WWT project work.	5 agencies working together on the nutrition strategy

### Partnerships

Objectives	Interventions	Impacts
By June 2009, at least 60% of impacts described in agency health plans promoting healthy eating /nutrition in pre schools, primary and secondary schools, are implemented and evaluated.	Membership of WPCP staff on steering committees. Enhance health promotion knowledge where appropriate. Work closely with relevant project workers to establish possible links to other projects/partners. Promote projects to agencies to share methodology, learnings and evaluation procedures. Strengthen and update the Body Friendly Schools Program currently being implemented in Wellington. Link the project with KGFYL and Smiles for Miles	Project partnerships between schools and health agencies, using Vic Health partnership tool or relevant equivalent are reviewed Project evaluation identifies work of the WPCP in building capacity for the project through partnership building New partners identified and involved in project work. WPCP partners have improved knowledge of relevant projects and the learning from the processes and protocols already developed and implemented. Outcomes/impacts of individual projects are achieved.

## Leadership

Objectives	Interventions	Impacts
By December 2007 WPCP will have recorded and presented relevant data to inform a community strategy regarding children and healthy eating in Wellington.	<p>Mapping of local practice in health agencies</p> <p>Evidence based strategies explored and made available to health orgs and schools</p> <p>WPCP to engage the Schools Focussed Youth Network YDHS and CGHS and their established networks to research what is happening in schools in the areas of healthy food and nutrition education.</p> <p>WPCP to work with working groups of Wellington Working Together to strengthen links between the networks</p> <p>WPCP to research changes in Government Policy with regard to healthy food, canteens etc in schools and ensure that member and broader community agencies are aware of updates.</p>	<p>Working paper produced and distributed. Strategy/direction formalised and circulated.</p> <p>Schools and health agencies report stronger links and more prevalent information sharing.</p>
By June 2009 40% schools will have established their own strategies for promoting healthy eating.	<p>Links between schools and agencies promoted through projects like KGFYL, Smiles for Miles and other relevant projects.</p> <p>Link with Wellington Working Together to strengthen work through the WWT young people's health networks.</p>	By June 2009 at least 40% of Primary Schools in Wellington will have established and implemented a nutrition policy.

## Workforce development

Objectives	Interventions	Impacts
By June 2009 WPCP will address at least 2 identified agency/school workforce development needs in terms of promoting healthy eating to children in Wellington.	<p>Survey agencies and schools as to needs.</p> <p>Ensure that member agencies are aware of what schools are doing.</p> <p>WPCP to promote relevant local policy to support Government directions.</p> <p>Bring agencies/schools together to discuss ways of addressing workforce development needs.</p>	<p>At least 5 schools and 5 agencies identify workforce development needs</p> <p>At least 2 identified needs are addressed.</p>

## Mental Health and Well Being

Priority goal: **To build the capacity of agencies to collaboratively plan a Wellington community approach to increasing awareness and knowledge of mental health and well being issues and their implications locally.**

### Organisational development

Objectives	Interventions	Impacts
By June 2008 there will be at least 6 new organisations aware of the determinants of mental health and the needs/issues of the catchment.	Survey organisations already involved in mental health to map current services and establish what current local issues are.  Facilitate a workshop to raise awareness of local issues	Survey completed.  Local issues paper distributed  Workshop completed and evaluated

### Partnerships

Objectives	Interventions	Impacts
By June 2009 at least 4 agencies will have collaboratively implemented one evidence based health promotion strategy to address one of the three determinants of mental health	Survey agencies as to what is happening in Wellington in terms of mental health promotion.  Ensure agencies are aware of the evidence around mental health promotion.  Bring organisations together for discussion and planning. Facilitate the process	Survey and audit of agencies carried out and recorded  Agencies are brought together for initial discussion.  Commitment to planning as a catchment in this area.

## Leadership

Objectives	Interventions	Impacts
During the life of the plan the WPCP will gain commitment from agencies to include mental health promotion and/or a focus on the three determinants of mental health within strategic plans.	<p>Engage agencies in discussion</p> <p>Local data collected and used to keep agencies informed of community needs.</p> <p>Support agencies to implement plans.</p>	<p>2 key agencies include mental health promotion in current plans.</p> <p>Commitment from agencies to have a mental health promotion component of their strategic plan</p>

## Workforce development

Objectives	Interventions	Impacts
By December 2009 at least 40% of key agency staff will have increased understanding and knowledge of the determinants of mental health in at least 3 Wellington PCP partner agencies.	<p>Highlight and promote information through WPCP newsletter.</p> <p>Support agencies running forums workshops and other educational activities in this area.</p> <p>WPCP to plan and implement at least two Vic Health mental health promotion awareness raising workshops/forums in Wellington by June 2008.</p> <p>Work with Gippsland Regional Health promotion to provide necessary training workshops. Eg mental health Promotion Short course</p> <p>Identify agencies which have a commitment and need for mental health promotion training.</p>	40% of agency staff will have participated in Mental Health Promotion short courses or other similar capacity building strategy.
	WPCP to organise Mental Health First Aid Training for health professionals working with drought affected families.	
By June 2008 at least 40% of key agency staff will have increased understanding and knowledge of the impact of family violence in at least 3 Wellington partner agencies.	<p>Support agencies in developing workforce education about the impacts of Family Violence where appropriate.</p> <p>Canvass agencies for commitment and support in this area.</p> <p>Communicate with key agencies and networks to raise awareness about family violence and its impact on mental health. Eg Gippsland Women's Health, WWT Family Violence working party</p>	Key staff attend relevant capacity building strategies in this area.

## 2.5 Estimated Resources – PCP IHP Catchment Resource Summary

Capacity Building Components	Physical Activity and Active Communities	Healthy Eating and Nutrition	Mental Health and Well Being
Partnership development	\$8742.60	\$7649.46	\$5463.90
Leadership	\$7330.73	\$7330.73	\$6283.48
Organisational development	\$6383.48	\$7330.73	\$7330.73
Planning and evaluation and dissemination	\$4035.50	\$3035.50	\$2035.50
Workforce development	\$5363.57	\$6374.55	\$6374.55
Totals	\$31,855.88	\$31720.97	\$27,488.16
Total PCP Resource/Budget Allocation	\$91,065.00		

### Notes:

This budget does not include carried over funds, unspent from the last budget due to staff vacancy.

These funds will be allocated to support IHP work in the next three years, as decided by WPCP agencies.

### Additional Integrated Health Promotion Resources

Funding source/project	Links to catchment priority	Funding
Healthy Active Living for Seniors	Physical Activity and Healthy Communities	\$40000 over two years
Falls Prevention – Gippsland Women’s Health Service	Physical Activity and Active Communities	\$ 210,000 over three years
<b>Totals</b>		\$250,000

## 2.6 Evaluation

Quality health promotion is dependent on meaningful evaluation which involves reflection on planning, processes and outcomes. Effective evaluation is part of a continuous planning cycle and within the Primary Care Partnership Strategy needs to reflect evaluation of capacity building processes short term, impact evaluation or objective assessment and outcome evaluation to measure the longer term effects of programs and objectives. Evaluation needs to reflect work at different levels and stages of integrated health promotion and partnership building.

Agencies need support to be part of an effective PCP evaluation process. The reasons behind the evaluation process are not necessarily understood or welcomed. Wellington PCP will work towards a greater understanding of why evaluation is an essential part of effective planning and implementation through on going discussion of evaluation at appropriate times during meetings, the availability of a WPCP evaluation plan which is reviewed at regular intervals at meetings, and developing an ongoing culture of self-reflection, discussion and adjustment accordingly. Evaluation reports will reflect all input and feedback, and be widely distributed and discussed.

Wellington Primary Care Partnership will employ a variety of evaluation strategies at varying stages of the implementation of the 2006 – 2009 Community Health Plan. A detailed evaluation plan will be produced by April 2007 to be implemented throughout the life of the Community Health Plan. Areas to be evaluated include:

### **1. Partnership/Network Effectiveness.**

On an annual basis the Wellington Primary Care Partnership will review the effectiveness of partnerships, networks and working groups which support WPCP work in the catchment area. This process will involve survey and discussion with individual agencies and working groups in addition to a more formal approach using either the Vic Health Partnership Analysis Tool or some other existing means if more appropriate. This process will be carried out firstly at the beginning of May 2007 when the catchment plan is fully operational and partners are engaged for the new year. This will provide a base level analysis for the duration of this plan. Clearly the analysis will provide information to inform actions for the rest of 2007 and may result in changes to strategies in the Community Health Plan. The partnership analysis will be repeated in June/July in subsequent years. A report of the analysis will form part of the yearly evaluation.

## **2. Capacity Building.**

Wellington PCP will produce an annual report evaluating capacity building processes for each priority area as outlined in the Community Health Plan. Impact indicators for each strategy will be assessed in terms of what has been achieved to that point.

Clearly agency member feedback will be an important part of assessing impacts. Discussion of the evaluation report at WPCP Business and Health Promotion meetings will be an important part of the evaluation process and could result in adjustment or even changes of direction for ongoing PCP capacity building.

## **3. Working Group Evaluation**

Where separate working groups or networks are operating in particular priority areas, evaluation of their achievements and processes will be completed through discussion on an annual basis. The Wellington PCP will support agencies involved to decide on an appropriate evaluation process and to implement it according to outlined objectives in the capacity building plan and individual network outcomes as defined by initial plans.

## **4. Three Year Planning.**

The final reporting/evaluation process would be completed at the end of the three year Community Health Planning period. This will include partnership analysis, working group evaluation and evaluation of capacity building processes and will involve input from member agencies and networks.

## **2.7 Applying an Integrated Disease Management 'lens' to IHP planning**

### **1) Integrated Health Promotion Interventions which prevent and/or delay chronic illness.**

Wellington PCP IHP plan has an emphasis on improving lifestyle factors that help prevent or delay chronic disease. The emphasis is on creating opportunities for a more active lifestyle with better nutrition and good mental health for the Wellington community.

At agency level, with WPCP support, projects like "Kids Go For Your Life" and "Body Friendly Schools" are working towards improving the health of our young people through education, addressing the barriers to access of information and providing supportive environments for eating healthy and being physically active. The aim is to motivate and provide support for our young people to choose a healthier lifestyle and hopefully prevent chronic diseases like cardio-vascular disease and type 2 diabetes in later life. The whole school community approach, involving school staff and a broad range of member agencies means that human and other resources are used effectively. The range of expertise both from health professionals and the community means that health inequity is more likely to be identified and addressed.

The PCP role is to ensure that the many agencies involved have the capacity to do this. Throughout the process the PCP will provide the opportunity to reflect on progress, provide direction where appropriate and identify training or resource needs. This multi-tiered approach will improve effectiveness and reach and create a broader mix of consistent interventions.

### **2) Specific Chronic Conditions and underlying social determinants in Wellington**

Wellington catchment data indicates that heart disease, diabetes and depression rates are on the increase. This combined with the already above average and increasing number of older people in Wellington makes for huge health costs both in monetary and human terms to manage these chronic diseases. Prevention is a far more economical and healthy option.

In response, Wellington PCP agency members are involved in a number of health promotion interventions to address the social determinants of health which underpin this challenging situation. Examples include raising awareness of family violence (a major cause of depression amongst women) and, in response to community

opinion, increasing the number of strength trainers for Seniors in Wellington to build community capacity for more active Senior involvement.

### **3) Barriers to participation, inclusion and well being**

The Wellington PCP CHP aims to have a greater alignment with the Wellington Shire Council's, Positive Ageing Strategy, which is aimed at addressing barriers to participation by older members of the community. Extensive community consultation has informed this strategy which aims to make inclusion in activity far easier for older people who may suffer from chronic disease.

The PCP Chronic Disease Management Model roll out in Gippsland and the CDM education and training strategy, include a focus on addressing health inequity, including specific training modules on this aspect.

A strategy to strengthen links with Ramahyuck aims to look at ways of being more inclusive of the indigenous community in all aspects of the Community Health Plan.

### **4) Broader impacts of chronic illness in the Wellington Catchment.**

Chronic disease has far reaching effects on the community. GPs in Wellington are under enormous pressure from large workloads and community members find it difficult to see a GP at times. Rural areas like Wellington suffer from a shortage of GPs and allied health professionals. The more isolated areas, like Dargo, rely heavily on limited bush nursing services which are stretched and understaffed.

Distance and Wellington's more than average number of Senior citizens, mean that younger family members are not always available to provide family care. Professional carers are in short supply.

People on the land are becoming more isolated and depression and mental illness are on the increase. A significant number of farmers and their families suffer from chronic mental illness, with limited services available. Suicide rates for rural landowners are increasing and the demand on mental health services and violence workers is extremely high. Mental Health promotion is a major strategy in Wellington's Community Plan. Family Violence is also a focus of the mental health priority area.

### **5) Strategies to encourage an "upstream" approach.**

A major strategy for WPCP is to enable agencies to better understand the Social Model of Health and to collaboratively address the underpinning determinants. Partnership building, integrated planning and increasing

the capacity of agencies to address “upstream” issues is an important part of Wellington PCP’s approach. Providing evidence for the effectiveness of addressing “upstream” determinants is part of workforce development.

## Deliverable 3: Service Coordination

**Wellington Primary Care Partnership is committed to the quality of care and quality of life of people living in Gippsland through a coordinated, collaborative region wide approach to service coordination.**

The following Service Coordination Management Plan is the result of a planning process shared by the four Primary Care Partnerships in Gippsland.

Based on the health outcomes from the Better Health Care in Gippsland Project, Wellington Primary Care Partnership is committed to implement this regional plan at a local level.

## Gippsland Service Coordination and Chronic Disease Management Strategy 2006/09

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>SC Audit completed including annual reviews of Gippsland PPPS 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 PPPS Practice Manual</p> <p>Gippsland PPPS manual updated to reflect changes resulting from annual reviews and SC audit</p> <p>Gippsland PCP SC 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 sc 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 Divisions of General Practice</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 SC 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 Dec 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>

3. Successful implementation of the Victorian Service Coordination Practice Manual and subsequent versions of the Service Coordination Tool Templates.	Progress statewide SC standards and tools across the region	Victorian SC Practice manual Training Plan developed and evaluated  Review Gippsland PPPS Manual standards following the completion of the Statewide Service Coordination Manual.	Increased level of knowledge by health service staff of the Victorian SC Practice manual  Gippsland PPPS manual updates reflect Victorian SC Practice Manual
4. Change management support for implementation of e-referral.	Roll out e-referral across Gippsland	Gippsland PCPs, Divisions of General Practice and member agencies actively participate in Regional Gippsland Infoxchange PAG and PCP PAG's  Gippsland agencies develop and implement agency e-referral implementation plans  Gippsland PCPs develop support strategy for agencies to develop e-referral implementation strategies	Annual increase in the number of e-referrals sent  By June 2008 all Gippsland health and welfare services use e-referral to manage their external agency referrals  By June 2009, 20% of General Practices use e-referral to make referrals to state funded health and welfare services.
5. Improved amount and accuracy of information to support referral	Build up e-referral information	Gippsland PCPs support agency updating of GHA and Infoxchange service information systems	Annual increase in the number of agencies service information listed on the Statewide Human Services Directory

## Deliverable 4: Integrated Chronic Disease Management

**Wellington PCP is committed to 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.**

The following Integrated Chronic Disease Management Plan is the result of a planning process shared by the four Primary Care Partnerships in Gippsland.

Based on the health outcomes from the Better Health Care in Gippsland Project, Wellington Primary Care Partnership is committed to implement this regional plan at a local level.

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 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 chronic disease management 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>
<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>