



Banyule Nillumbik Primary Care Alliance

Community Health Plan 2006 – 2009

CRAFTING A BETTER HEALTH FUTURE IN PARTNERSHIP

Endorsed by PCP Chair

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Introduction

The Banyule and Nillumbik Primary Care Alliance (BNPCA) presents its fifth Community Health Plan (CHP). The CHP 2006 -2009 provides a strategic plan for the BNPCA to address its vision of improving health services leading to better health outcomes for the communities of Banyule and Nillumbik.

The CHP is divided into four Portfolio Areas:

- Partnership
- Integrated Health Promotion
- Service Coordination
- Integrated Chronic Disease Management

and has been prepared in consultation with member agencies of the BNPCA (see member agency listing in Portfolio 1: Partnership).

Policy Context

The CHP is created in the context of the State Government's three tiered policy framework.¹ This model comprises, at the highest level of social policy, *Growing Victoria Together and A Fairer Victoria*. These policies commit the government to high quality, and accessible health and community services. They also establish a framework for the BNPCA to address disadvantage by developing and implementing innovative approaches to service delivery.

The next level of policy which is more specific to health is *Care in your community*. This sets out a framework for a consistent approach to the development of a health care system that is integrated and coordinated around the needs of people. It emphasises the following specific values that inform the development of the Victorian healthcare system:

- The best place to treat
- Together we do better
- Technology to benefit people
- A better health care experience
- A better place to work

This policy encourages a change in planning and investment to make sure the best mix of inpatient and community-based integrated care services is achieved. It will support the BNPCA initiatives around the growth of prevention, early intervention, self-management and health promotion. *Care in your community* describes five critical enablers to support the delivery of person and family-centred health care in integrated community-based settings. These are:

- Funding models
- Workforce
- Integration tools
- Information and communication technology
- Partnerships

¹ Primary Health Branch: Policy and funding guidelines 2006 -07 to 2008 – 09, Department of Human Services, 2006

The policy level most directly related to this Community Health Plan includes the Primary Care Partnerships (PCP) Strategy and the *Community Health Services – creating a healthier Victoria*. The latter provides a framework to build a sustainable and effective community-based health services as a key component of an integrated “whole of health” system. This PCP strategy endorses the role of PCP’s as an integral part of the Victorian health and human services sectors, recognising that agencies working in partnership towards shared goals can achieve better health outcomes. Within this context the BNPCA will continue its growth into other primary health care service providers, such as drug & alcohol, mental health and palliative care, along with appropriate non- primary health sectors such as education, disability and housing.

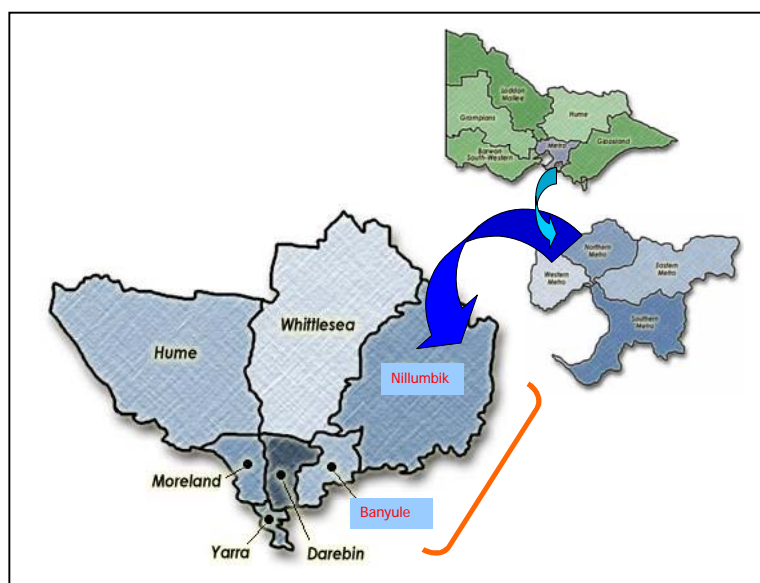
The current role of PCPs is to facilitate change management in partnership development, integrated health promotion and service coordination. In addition, although improving health outcomes for those with chronic and/or complex conditions has always been a priority for the BNPCA, Integrated Chronic Disease Management is now incorporated as a specific portfolio within this Plan.

BANYULE NILLUMBİK COMMUNITY PROFILE

Key Demographic & Social Characteristics

Banyule is located 15 kilometres north east of Melbourne. It is primarily residential; Nillumbik is adjacent to Banyule’s north eastern area. The southern part of Nillumbik is primarily urban and residential; its northern area includes rural areas and National Parks.

Figure 1 State, Regional and LGA DHS areas.



In 2001, the catchment area had a total population of nearly 176,600 persons, with two-thirds living in Banyule. Banyule covers 63 square kilometres and Nillumbik covers 435 square kilometres. Banyule has a relatively high population density of 1,884 persons per square kilometre, compared with Nillumbik which has a population density of 133 persons per square kilometre.

Age Profile

The age profile for Banyule and Nillumbik is similar to the Victorian average, with a slightly below average level of residents' aged 65 or more in 2001 (19,726 in total 11%). Over the next two decades. The number of older persons aged 65+ is forecast to increase in Banyule-Nillumbik' by 72% or by (3890 in Nillumbik by 2011) and (14,666 in Banyule by 2031).

Almost half the population of both LGA's are aged between 30 – 60 years (Banyule 42.3% Nillumbik 47.7%). Nillumbik has a slightly higher level of 15-24 year olds than Banyule (14.8% compared to 13.4%); Persons aged 65+ have the highest hospital admission rates for all Banyule-Nillumbik residents (BNPCA Community Profile 2001). Banyule currently has a much higher proportion of residents aged 65 or more (16.3% compared to 7% in Nillumbik).

Socio-Economic Status & Unemployment

Whilst many Banyule and Nillumbik residents enjoy relatively high levels of social advantage, there is significant social and economic disadvantage across both LGAs. The catchment area also has relatively low levels of unemployment.

A study completed by Jesuit Social Services (1999) indicated that West Heidelberg ranked third in Melbourne and seventh in the state as one of the most disadvantaged localities. In 2001 the IRSED ranking for Banyule was 68 with a score of 1058 compared with Nillumbik 75 and 1108.

Household status

	Banyule %	Nillumbik %
Single Person Households	22%	12%
Households of 4 or more	31%	44%
Single Parent Families	15%	10%
Homes fully owned or purchasing	75%	86%

Public Transport

Access to public transport for Banyule residents is around 78%, which can be compared with 39.1% for Nillumbik

Country of Birth

Banyule has a well below average level of residents who were born in non-English speaking countries. Most Banyule residents were born in Australia – 75%. The main overseas countries of birth for Banyule residents were the United Kingdom (3.2%), Italy (2.4%), Greece (1.1%), New Zealand (0.9%) and Germany (0.6%). Banyule has a lower number (14.3%) of residents born in non-English speaking countries than the average for Melbourne (22.2%).

Nillumbik has an even lower level of residents who were born in non-English speaking countries with 82% of Nillumbik residents being born in Australia. The main overseas countries of birth for Nillumbik residents were the United Kingdom (4.7%), Italy (1.4%), Germany (0.7%), New Zealand (0.8%) and the Netherlands (0.5%).

ATSI Residents

Across the Banyule-Nillumbik catchment area, indigenous persons accounted for less than 0.4% of the total population in 2001 - 617 persons, with the vast majority of these living in Banyule. As can be seen from the following table this component of the Banyule population has been steadily increasing².

² See Banyule Municipal Population Snapshot 2006. Briefing paper prepared by Social Planning Unit Banyule City Council

Population Growth

Year	No. of Aboriginal persons in Banyule
1986	224
1996	381
2001	484

Source: ABS, Census of Population and Housing, 1986, 1996 and 2001

This group is significant because of its experience of social and health disadvantage, and issues associated with providing access to mainstream support services.

Selected indicators of disadvantage

Indicator	Banyule aboriginal	Banyule non-aboriginal
One parent families	32%	15%
Unemployment rate	13.5%	4.9%
Median weekly disposable income	\$332	\$420
Rental housing	55%	19%

Source: Indigenous population and social data. ABS 2001

Health & Wellbeing Status

Both males and females in Banyule and Nillumbik have a better than average health status than the Victorian population. Male Life Expectancy for the catchment in 2004 was 80.5 compared with the State average (79.6) and N&WMR average (79.7). Female Life Expectancy although higher at 83.7 is less than that of both the State (84.3) and regional (84.4) averages.

Male DALY Rates for Selected Diseases – 2001

Disease	Nillumbik Rate	Banyule Rate	Vic Metro Rate
Cardiovascular Disease	448.9	1477.0	40592.1
Ischaemic heart disease	252.7	854.8	23431.5
Cancer	584.3	1781.6	48319.8
Lung cancer	96.5	330.9	9634.0
Prostate cancer	83.2	303.6	7634.2
Chronic Respiratory Conditions	223.7	583.6	16532.6
Emphysema/chronic bronchitis	71.2	259.6	7556.9
Neurological Disorders			
Dementia	66.3	288.2	7138.7
Parkinson's	23.0	90.6	2315.2

(Source: Burden of Disease (2001) Banyule Nillumbik <http://hns.dhs.vic.gov.au>)

Female DALY Rates for Selected Diseases – 2001

Disease	Nillumbik Rate	Banyule Rate	Vic Metro Rate
Cardiovascular Disease	376.0	1504.6	37471.2
Ischaemic heart disease	155.5	697.8	17369.1
Cancer	598.1	1747.9	44707.3
Breast cancer	192.7	461.9	11572.8
Lung cancer	67.0	230.9	6066.4
Chronic Respiratory Conditions	207.4	568.7	16443.7
Asthma	110.6	188.6	6422.9
Emphysema/chronic bronchitis	60.8	225.2	5994.3
Neurological Disorders			
Dementia	106.0	483.1	11734.8
Parkinson's	19.1	78.7	1953.2
Musculoskeletal Diseases	38.4	326.7	9156.9

(Source: Burden of Disease (2001) Banyule Nillumbik <http://hns.dhs.vic.gov.au>)

Disability

In 2001 it was estimated that approximately 24,126 people living in the BNPCA catchment suffered from some sort of disability.

Disability Type Nillumbik / Banyule

Type of Condition	No. (Nillumbik)	No. (Banyule)
Acquired Brain Injury	151	433
Psychiatric	543	1054
Intellectual	245	415
Sensory	815	2,295
Physical	5,055	13,120
Total	6,809	17,317

(Source: Department of Human Services, Disability Services June 2001)

Mental Health

Whilst lower than the Victorian averages, there are still a significant number of people suffering with mental health issues across Banyule and Nillumbik.

DALY Rates for Males with Mental Disorders and Suicide

Causes	Nillumbik Rate	Banyule Rate	Vic Metro Rate
Mental Disorders			
Alcohol abuse/dependence	39.2	74.5	2661.9
Heroin abuse/dependence	40.2	80.8	2843.4
Schizophrenia	44.5	96.7	3116.6
Depression	150.0	341.5	10484.2
Bipolar disorder	5.3	30.4	1297.5
Social phobia	32.3	59.7	1828.5
Generalised anxiety disorder	51.4	95.6	2929.3
Borderline personality disorder	37.2	88.6	2612.5
Intentional Injury			
Suicide	101.2	199.1	6236.9

(Source: Burden of Disease (2001) Banyule Nillumbik <http://hns.dhs.vic.gov.au>)

DALY Rates for Females with Mental Disorders and Suicide

Causes	Nilumbik Rate	Banyule Rate	Vic Metro Rate
Mental Disorders			
Alcohol abuse/dependence	16.3	25.9	746.3
Heroin abuse/dependence	9.8	28.2	863.4
Schizophrenia	42.9	77.6	2465.3
Depression	177.0	367.2	12316.5
Bipolar disorder	26.4	35.4	1453.8
Social phobia	40.2	71.1	2223.5
Generalised anxiety disorder	109.7	207.2	6233.4
Borderline personality disorder	48.3	73.4	2835.3
Intentional Injury			
Suicide	43.0	83.0	2364.6

(Source: Burden of Disease (2001) Banyule Nilumbik <http://hns.dhs.vic.gov.au>)

Hospital Admissions

The main hospital servicing the BNPCA catchment is the Austin. In the financial year 2005-06, the hospital had a 6.0% increase in total admissions and a 15.9% increase in patients treated in the hospital emergency department compared with 2004-05. Mental health Emergency Department presentations have increased by 20.3% over the last year. There were 1,874 people waiting for elective surgery at the end of June 2006 compared with 2,418 in June 2005, a decrease of 22.5%

Ambulatory Care Sensitive Conditions

Ambulatory Care Sensitive Conditions (ACSCs) are those for which hospitalisation is thought to be avoidable if preventive care and early disease management is applied, usually in an ambulatory setting. ACSC's are divided up into chronic, acute and vaccine-preventable.

The admission rates for ACSCs for the BNPCA catchment have increased over the six year period with only diabetes and iron deficiency complications being currently higher than the overall Victorian average. Diabetes complications remained the PCP's leading cause of hospital admissions in 2002-03. Over the past two years the average bed days for the top 10 ACSC's has fallen from 5.16 to 4.90.

ACSCs in Banyule/Nilumbik 2002-03

ACSCs	No. Admissions	Rate / 1000 persons	Av. Bed Days	Total Bed Days
Diabetes complications	1,084	6.11	9.67	10,479
Dental Conditions	564	3.17	1.20	677
Dehydration & Gastro-enteritis	447	2.50	1.91	855
Chronic Pulmonary Disease (CPD).	396	2.27	6.22	2,463
Pyelonephritis (Kidney Disease)	293	1.64	4.75	1,391
Congestive Cardiac Failure	282	1.54	6.42	1,811

(Source: The Victorian Ambulatory Care Sensitive Conditions Study 2002-2003 Update)

Carers

Carers have been defined as being those who provide some assistance to those who need help because of disability or ageing (ABS, 1998). In March 2001, Banyule had more than 2,000 residents receiving the carer's allowance. The available data indicates that roughly half were adult carers and half were carers of adults and half were carers of children with disabilities. Nillumbik had more than 430 residents receiving the carers' allowance. However, because many carers are hidden this figure is regarded as an underestimate.

Municipal Health Plans

The Banyule City Council Health Plan 2004 – 2007 contains the following goals to meet its vision of "Building a health community together"

1. Promote Healthy Living
2. Promote integrated health and community service planning
3. Promote a stronger, connected and active community
4. Promote community safety
5. Protect and improve Banyule's built and natural environment.

Nillumbik Shire Council in its Municipal Public Health Plan 2006 - 2009 "Healthy Living in Nillumbik" has a similar set of goals. These are:

1. Develop and maintain a healthy and sustainable environment
2. Protect, maintain and promote good health and active living
3. Enhance safety and improve accessibility within the community and in public spaces
4. Foster a more involved, connected community through enhanced participation and partnerships

Portfolio 1: Partnerships

In the last 12 months the BNPCA has enabled and facilitated a number of key achievements, including:

- Development of trust and cooperative working relationships between agencies
- Attracting financial resources to the community through collaborative approaches
- Providing practical strategies to assist in the interpretation and implementation of DHS priorities

PARTNERSHIP VISION

The agreed vision for BNPCA for the period 2006 – 2009 is:-

Partners in health, working together, to promote improved health services and better health outcomes

This is interpreted as meaning, through partnership we will be able to:

- Strengthen community capacity to benefit consumers, carers and the broader community
- Improve planning and integration
- Streamline information flow
- Promote consultation and where appropriate, undertake an advocacy role with government
- Drive, encourage and influence the sector

In developing and carrying out this vision the BNPCA agencies have agreed to the following underpinning principles:

- Working collaboratively and cooperatively to enhance the capacities of member agencies and the viability of services
- It is expected that providers will advice and consult with other Alliance members of any proposed significant changes to their services, which may impact on partnership arrangements
- Open communication and consideration of the views of member agencies
- Negotiation and mediation where differing opinions exist
- Open mindedness, flexibility and reflective criticism as required
- Sharing information
- Respect for agency roles and agency complementarity
- Integrity
- Commercial confidentiality
- Client confidentiality

In three years time we hope to have an evolving partnership with complimentary agencies committed to working in partnership for the benefit of the community. The Alliance will be able to deliver DHS priorities as well as locally relevant goals set by the Strategic Partnership Group. The BNPCA will be operating at a strategic level whilst also responding to new initiatives offered by the Government to enhance the current program delivery available in the catchment.

ACHIEVING THE VISION

The following Partnership goals have been agreed to for the next three years:

Goal 1: *Participation in proactive planning opportunities within and beyond the Alliance*

Goal 2: *Development and expansion of the membership base with the inclusion of complimentary agencies committed to the Alliance vision*

Goal 3: *Maintain a communication and promotion strategy*

Challenges

In order to reflect on strengths and weaknesses of the BNPCA partnership the Vic Health Partnership Tool will be utilized during the first year of this plan. An ongoing challenge will be to keep member agencies active and committed to the work of the Alliance at each of its various levels. A new challenge will be to manage the integration of new members whilst limiting the impact on existing working relationships between partner agencies, as the membership becomes more diverse and encompasses a variety of stages of involvement.

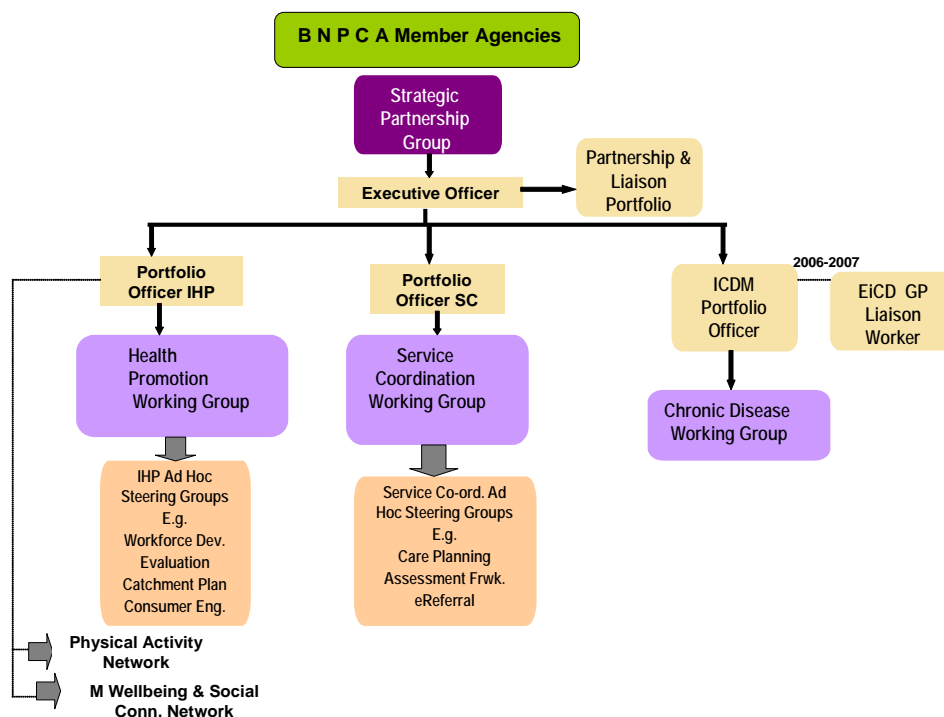
Capacity Building

The BNPCA will achieve a robust and flexible partnership through the capacity building activities listed in the Partnership Strategic Plan and also in the following ways:

Organisational Development

From 1 July 2006 the BNPCA implemented a revised structure. The new structure emerged following workshop deliberations regarding strategic priorities and the desire to streamline structures and processes and avoid any potential overlap of meetings in the future. This revised structure also incorporated the development of an Executive Officer role, which will provide regular reports to the Strategic Planning Group and operates within a Delegation of Authority statement. This position is supported by specific Portfolio Officers, who will prepare and be guided by a detailed Portfolio Implementation Plan.

Figure1: Revised BNPCA Structure



A description of these various levels in the BNPCA structure is provided below:

The Strategic Planning Group (SPG) is responsible for:

- High order decision making
- Allocation of a contact agency for DHS Service Agreement (funds holder and employer responsibility)
- Partnership liaison
- Catchment planning
- Policy and advocacy
- Members of SPG are CEO's or senior managers within key member agencies

The Executive Officer is responsible for:

- Ensuring the implementation of the Community Health Plan
- Reporting on behalf of all priority areas against work plans to SPG
- Providing summary reports and recommendations in advance to SPG for discussion and decision making
- Partnership liaison
- Representing the BNPCA at appropriate networks and meetings
- Managing Portfolio Officers

The Portfolio Officers are:

- Responsible for the implementation of their Portfolio implementation plan
- Supporting Portfolio Working Groups
- Regular communication with Portfolio representatives from member agencies
- Working to detailed Portfolio plans with clear strategies and key performance indicators
- Providing regular reports to SPG via Executive Officer

The Portfolio Working Groups are responsible for:

- Assisting with the implementation of their Portfolio implementation plan
- Receiving reports from ad hoc steering groups
- Members are representatives from various member agencies, whose position in their agency is relevant to the Portfolio area, often at a manager or team leader level, although sometimes in small organisations they may also be practitioners

Portfolio Steering Committees are responsible for:

- Specific area of Portfolio work to be progressed in a time limited manner
- Members selected will have relevant expertise and are expected to represent their agency position, as well as influence the agency in progressing the specific area of responsibility

Workforce Development

In each of Portfolios the goals and objectives have reflected the broad status of current skill and knowledge levels along with identified key gaps. The Implementation Plans for each of the Portfolios identify the approach to be taken to address these. They range from large forum events and training workshops, through the use of guidelines and manuals, to the support of Portfolio Officers and mentoring/peer support.

Leadership

The BNPCA Strategic Partnership Group has representatives from the following member agencies:

- Austin Health
- Banyule City Council (Contact Agency and employer)

- Banyule Community Health Service (Host to BNPCA staff)
- Neami
- Nillumbik Community Health Service (Chair)
- Nillumbik Shire Council
- North East Valley Division of General Practice
- Northern Health - BECC
- Royal District Nursing Service (Deputy-Chair)

and the Department of Human Services

The BNPCA has demonstrated a strong leadership role as in Portfolio 2 through the integration of relevant member agency plans, into a BNPCA Catchment Plan, including:

- Municipal Public Health Plans for Banyule and Nillumbik Council's,
- Community Health Service – BCHS and NCHS Integrated Health Promotion Plans,
- Women's Health in the North – Integrated Health Plans and
- The inclusion of expressed plans of other agencies, that relate to the BNPCA priority areas.

Leadership around health inequalities is also represented in several ways.

The initiatives outlined in the Integrated Health Promotion Plan,

- Involvement in the Heidelberg West Neighbourhood Renewal Project,
- Preparation of joint submissions targeting health inequalities and
- Working with Banyule City Council in the Banyule Health Inequalities Learning Project.

Partnership

Within the BNPCA catchment there is a Neighbourhood Renewal site at Heidelberg West. Considerable collaboration has already occurred with this Project in relation to the Steering Committee and the preparation of a recent funding submission. Once the Neighbourhood Renewal governance structure is in place, it is expected that the BNPCA will contribute to the Health and Well Being Working Group as indicated in the Integrated Health Promotion Plan.

The Early Intervention in Chronic Disease (EliCD) "*Health for Life*" initiative and the Lifescrpts Project have, and will continue to, strengthen the BNPCA partnerships with GPs. The allocation of funds for the EliCD GP Liaison Worker position within the current financial year has played a pivotal role in this regard. It is hoped that the expertise and relationships built during this project with the Banyule Community Health Service will later be extended to other primary health care settings.

The BNPCA has strong links with both Local Government councils in the catchment. These will continue as the Councils enact their MPHP and implement their integrated planning across council programs. The Banyule Health Inequalities Learning Project is an example of a Local Government working together with BNPCA to build capacity across the catchment.

Resources

The Strategic Partnership Group has considered the most appropriate use of the funding available to it for the ensuing 12 months. Most financial resources are being allocated to staffing and associated costs of running the Alliance. The BNPCA will seek additional resources such as funds to support the expansion of eReferral rollout. It will also assist agencies to attract new funding initiatives into the catchment that are in line with priority areas identified in this plan. The BNPCA will also utilise external specialist support as required

ACHIEVING THE GOALS - PARTNERSHIP

The BNPCA has set the following goals and objectives in relation to strengthening the partnership and achieving the vision during 2006 -2009:
Please note: Capacity Building Components: Organisational Development (OD), Workforce Development (WD), Resources (R), Leadership (L), Partnership (P) are noted in the Estimated Impact column.

Goal 1: Participation in proactive planning opportunities within and beyond the Alliance (N/W Metro. Region catchment & inter-catchment opportunities)		
Objective	Strategy / Intervention	Achievement Indicators
1.1 Participate in planning opportunities beyond the local PCP catchment	<p>Year 1 Participation in the 'Planning for a Healthier North' Health Planning Leadership Forum series 2006 and contribution to the Healthier North plans for a further 12 month program (WD, L & P)</p> <p>Participation in Austin Health PC & PHAC (L & P)</p> <p>Year 2 Participate in further opportunities that could progress area based planning (WD, L & P)</p> <p>Participation in Austin Health PC & PHAC (L & P)</p> <p>Year 3 BNPCA to adopt an area based planning model as the preferred future planning process (L, P)</p> <p>Review structures, roles and responsibilities required to adopt an area based planning model (OD)</p> <p>Participation in Austin Health PC & PHAC (L & P)</p>	<p>80% of invited BNPCA representatives attended all forums</p> <p>Reports from BNPCA provided to each meeting and Increased sharing of information between acute and primary care sectors (WD, L & P)</p> <p>Opportunities to progress area based planning are utilized by attendance at future forums</p> <p>As before</p> <p>BNPCA will complete the new Community Health Plan using area based planning model</p> <p>New structure identified to support area based planning is drafted for implementation in July 2009</p> <p>As before</p>
1.2 Work collaboratively with neighbouring PCPs	<p>Year 1 Implement agreed collaborations with NCM PCP in the Service Coordination Portfolio and Integrated Health Promotion Portfolio (P)</p> <p>Year 2 Seek other opportunities to work collaboratively with particular regard to engaging new sectors and future workforce development options (WD & P)</p>	<p>Stronger relationship with NCM PCP is developed as measured by initiatives completed and new opportunities for other collaborations identified</p> <p>Joint workforce development opportunities for SC & IHP are provided and new opportunities identified</p>

	<p>Year 3 Review collaborative work to determine the benefits to both PCPs and identify further opportunities (P & OD)</p>	Representatives from both PCPs meet to discuss future of collaborative work
<p>1.3 Contribute to new initiatives focussed on addressing disadvantage</p>	<p>Year 1 Participate and support relevant Heidelberg West Neighbourhood Renewal activities (P)</p> <p>Participate in the Banyule Health Inequalities Learning Project (P & WD)</p> <p>Year 2 Participate in Health and Well Being Working Group of the Heidelberg West Neighbourhood Renewal activities (P)</p> <p>Year 3 Participate in Health and Well Being Working Group of the Heidelberg West Neighbourhood Renewal activities</p>	<p>Attendance by BNPCA representatives at Health & Well Being Working Group meetings. Regular contact with the Place Manager</p> <p>Development of Health Equity Tools Strategies to improve advocacy for service access and appropriateness for people with disabilities, indigenous people and refugees.</p> <p>As before</p> <p>As before</p>
<p>1.4 Approaches to address disadvantage and health inequalities as part of BNPCA strategic planning</p>	<p>Year 1 Year 2 Include outcomes from the Banyule Health Inequalities Learning Project in future submissions and planning activities (L & P)</p> <p>Determine what constitutes the most disadvantage across the 2 LGA's in catchment (L & P)</p> <p>Use local health and planning data to identify the top 3 most disadvantaged postcodes in the BNPCA Catchment (L & P)</p> <p>Year 3 Using identified model to pilot improved access to information and services for these top 3 postcodes (R)</p>	<p>Improved availability of data on local disadvantage and health inequality as measured by data dissemination</p> <p>List of factors leading to the most disadvantage identified</p> <p>3 most disadvantaged postcodes identified</p> <p>At least one program implemented to address disadvantage and health inequality</p>
<p>1.5 Identification of new initiatives that will enhance existing services and projects across the catchment</p>	<p>Year 1, 2 & 3 Consider new opportunities that are consistent with BNPCA priorities (L & P)</p> <p>Support member agencies, to the extent that resources are available, in applying for funding of initiatives that fit with BNPCA priorities (P & R)</p>	<p>3 opportunities that are consistent with existing services and priorities are considered</p> <p>80% of requests for support are provided</p>

Goal 2: Development and expansion of the membership base with the inclusion of complimentary agencies committed to the Alliance vision

Objectives	Strategies / Interventions	Achievement Indicators
<p>2.1 Regular review of BNPCA Partnering Agreement, including governance and staffing arrangements</p>	<p>Year 1 Review BNPCA Partnering Agreement and Delegation of Authority; governance structure and staffing arrangements (L, P & OD)</p> <p>Review SPG meeting format and frequency (P & L)</p> <p>Year 2 Based on Year 1 experience, review and refine Partnering Agreement and Delegation of Authority (I, P & OD)</p> <p>Year 3 Review BNPCA Partnering Agreement and Delegation of Authority (L,P & OD)</p>	<p>New Partnering Agreement and Delegation of Authority (including structure and staffing arrangements) is ratified by SPG member agencies</p> <p>SPG Agenda reflects capacity building and operational matters</p> <p>Ratified by SPG member agencies</p> <p>New Partnering Agreement and Delegation of Authority (including structure and staffing arrangements) is ratified by SPG member agencies</p>
<p>2.2 Aim to improve partnership relationship over the 3 years</p>	<p>Year 1 Complete VicHealth Partnership Tool to establish level of partnership and strengths and weaknesses experienced by SPG members (P)</p> <p>Organise BNPCA Member Forum and invite new sectors to showcase Alliance achievements and the benefits of partnerships (P)</p> <p>Year 2 Based on results of Partnership Tool determine an agreed progression plan to progress partnership levels (P)</p> <p>Implement Partnership Progression Plan (P)</p> <p>Year 3 Complete VicHealth Partnership Tool and compare level of partnership between Strategic Partnership Group members with Year 1 results (OD & P)</p>	<p>Baseline for the level of partnership BNPCA is established and strengths and weaknesses identified</p> <p>Membership Forum conducted with new sectors being involved</p> <p>The plan is accepted by all SPG members</p> <p>Tasks listed in plan are commenced</p> <p>Comparison between Year 1 and Year 3 will demonstrate improved partnership</p>

<p>2.3 Review membership base and category of membership at the commencement of each year</p>	<p>Year 1, Year 2 & Year 3 Contact all member agencies to establish preferred type of membership and portfolio interest (OD & P)</p>	<p>Survey of member agencies completed and appropriate membership allocated. New updated contact lists for each Portfolio area are prepared</p>
<p>2.4 Identify sectors that are under represented and develop a strategy to engage them in Alliance activities</p>	<p>Year 1 Consider the priority areas identified throughout the CHP and identify any influential sectors that are under represented in Alliance activities (P) Approach Palliative Care agencies about involvement in Alliance activities (2 agencies) (P) Continue participation in BN Youth Services Network and NCC Project (Disability Sector) (P) Respond to interest shown by local agencies wishing to be involved in BNPCA activities (P)</p> <p>Year 2 Target Drug & Alcohol and Mental Health agencies (at least 2 agencies from each sector) about involvement in Service Coordination (P) Consider Employment, Education and Housing sectors in relation to IHP (P)</p> <p>Year 3 Work with Family Services agencies, particularly Berry St. and Children's Protection Society to include them in appropriate BNPCA activities (P)</p>	<p>Estimated Impact across all strategies and years: Under represented sectors are identified and a strategy to engage them in Alliance activities is developed and implemented (P) 2 Palliative Care, 2 Drug and Alcohol and 2 Mental Health agencies engaged and signed up to Partnering Agreement by the end of Year 2 (P) Representative from new agencies attend at least 3 BNPCA meetings in Year 2 and 6 meetings in Year 3 (OD, WD & P) 2 new sectors represented in IHP activities Able to report on examples of expanded collaborative work within the Alliance (P)</p>
<p>2.5 Review Consumer Participation in BNPCA activities</p>	<p>Year 1 Reflect on HIC report on PCPs and Consumer Participation (WD)</p> <p>Year 2 Review BNPCA strategy/policy regarding Consumer Participation (OD)</p> <p>Year 3 Decide on ongoing strategy/policy regarding Consumer Participation (OD, L & P))</p>	<p>1 SPG meeting considers issue of Consumer Participation in PCP and member agencies</p> <p>1 SPG meeting reviews BNPCA Consumer Participation Policy</p> <p>1 SPG meeting dedicated to develop ongoing Consumer participation strategy/policy</p>

Goal 3: Maintain a communication and promotion strategy		
Objectives	Strategies / Interventions	Achievement Indicators
<p>3.1 Ensure PCP communication is by the preferred method of a majority of agencies and that all communications are conducted in a timely manner</p>	<p>Year 1 Survey membership about preferred method and frequency of communication (OD)</p> <p>Consider producing BNPCA Strategic Plan Brochure (P)</p> <p>Year 2 Implement results of preferred communication (OD)</p> <p>Year 3 Undertake a review of BNPCA image and branding in light of expanded membership (P)</p>	<p>Survey results are analysed</p> <p>Improved marketing of BNPCA to new sectors and potential stakeholders</p> <p>Results of communication survey are implemented</p> <p>Review is completed and decision made about title of Alliance and appropriate branding</p>
<p>3.2 Review and maintain the Website to ensure it is a site of preference for agencies seeking the latest data and relevant information about the various PCP activities and a comprehensive listing of training opportunities</p>	<p>Year 1 Undertake a review of the website to ensure it is up to date and meets members needs (R & P)</p> <p>Ensure regular Top Story is available for distribution through monthly Infocast (P)</p> <p>BNPCA member agencies use the website to gain access to BNPCA documents (R)</p> <p>Launch and promote new Training Page (R)</p> <p>Maintain training page with all training opportunities relevant to primary care workforce (WR & R)</p> <p>Year 2 Broaden Training opportunities provided through website, eg. NEVDGP training listed (R)</p> <p>Year 3 Investigate the incorporation of a proactive tool for membership base to link particular training topics to specific groups of interested staff (R)</p>	<p>BNPCA Website is reviewed and maintained with regular, current, and interesting updates</p> <p>Members receive regular updates on initiatives and BNPCA activity</p> <p>Members able to access BNPCA documents as required</p> <p>A readily accessible and up to date Training Page offering a wide range of relevant and appropriate training opportunities is made available</p> <p>3 new sources of training are incorporated in Training page</p> <p>Proactive tool introduced for interested staff</p>

BNPCA MEMBER AGENCIES

Member Agencies	Strategic Partnership Group	Integrated Health Promotion Group	Service Coordination Group	Integrated Chronic Disease Management (EiCD Steering Committee)	Affiliated with BNPCA
Austin Health	X	X	X	X	
Australian Polish Community Services			X		
Banksia Palliative Care					X
Banyule & Nillumbik Primary Mental Health Team					X
Banyule City Council	X	X	X	X	
Banyule Community Health Service	X	X	X	X	
Banyule Information and Support Centre					X
Baptist Community Care			X		
Berry St Community Resource Centre					X
Bundoora Extended Care Centre (Northern Health)	X	X	X	X	
Carer Links North			X		
Centrelink		X			
Children's Protection Society					X
Co As It					X
Community Information Diamond Valley					X
Community Rehabilitation Centre, ARMC					X
Coordinated Health Care			X		
Dept of Human Services	X	X			
Heidelberg Aged Care Assessment Service			X		
Heidelcare					X
Hope Springs					X
Interchange Northern Region Inc			X		
Melbourne City Mission Eltham Retirement Village			X		
Kalparrin – Early Childhood Services		X			X
La Trobe University – School of Human Communications Science					X
Linkages Bundoora Extended Care Centre					X
Linlithgow (Community Organisation)					X
Migrant Resource Centre North Eastern Region					X

Moreland Hall					X
NEAMI	X	X			
Nillumbik Community Health Service	X	X	X		
Nillumbik Shire Council	X	X	X		
North East Valley Division of GPs	X		X	X	
North East Post Acute Care			X		
Northern CAMHS					X
Northern CASA					X
Omnicare, Personal Care Agency			X		
Royal District Nursing Service	X		X	X	
Richmond Fellowship of Victoria					X
Rosanna Fire-station Neighbourhood					X
Southern Cross Victoria Aged Care					X
Third Age					X
Vision Australia		X			
Warringal Private Hospital					X
Wesley Do Care Northern Region					X
WINN Support Services					X
Women's Health In the North		X			

Portfolio 2: Integrated Health Promotion

IHP VISION & GUIDING PRINCIPLES

To work in a collaborative partnership with key stakeholders, in order to address the broader determinants of health and to impact positively on the health and wellbeing of the Banyule and Nillumbik communities. This will be achieved within a systematic inter-agency and inter-sectoral framework that maximises the health promotion efforts of member agencies, and through effective catchment planning, implementation and evaluation.

In addition to endorsing the seven guiding principles/core values for integrated health promotion³ the Working Group also wished to adopt the following process guidelines:

1. We will share expertise and information
2. We will coordinate our efforts to create enhanced outcomes
3. We will ensure that our activities and projects will contribute to and be guided by an overall health promotion plan for the catchment area

PRIORITY SETTING AND PROBLEM DEFINITION

The BNPCA has recognised that the change in IHP strategic directions would necessitate a major transition phase, and that this would commence with the development of an agreed catchment planning framework for the BNPCA which aims to:

- expand and strengthen collaborative partnerships,
- improve the quality of integrated approaches to health promotion planning, implementation, evaluation and dissemination,
- move toward a population health based approach for health promotion activity, and
- ensure that resources reflect the agreed vision and strategies.

The BNPCA Integrated Health Promotion Working Group (IHP WG) has played a central role in priority setting for the plan. In summary, the development of this Catchment Plan is based on planning processes with the following elements:

- Health Promotion program/project mapping
- Review of Integrated Planning through Municipal Public Health Plans

The framework process devised (as set out under Organisational Development), sought to create environments that would achieve improved health equity and represented an effort to:

- Recognise the strategic essence of Catchment Planning and enable the IHP WG to focus on the provision of strategic direction rather than project specific direction.
- Provide a guidance tool for member agencies to use in devising their own 'on the ground' plans which are reflective of agreed strategic directions and priority areas.
- Facilitate a greater concentration on the announced PCP priorities of workforce development and capacity building by not tying the BNPCA to extensive levels of specific project development and management.

³ Department of Human Services, Victoria. "Integrated Health Promotion Resource Kit" June 2003. p.5.

- Encourage greater cross-sectoral IHP capacity, through its inherent flexibility and recognition of the broader determinants of health.
- Improve our capacity to attract new members who are able to join-in at the level, (and to the degree) that they feel most competent in being able to contribute.
- Recognise that Agency involvement is essential to develop a sense of ownership and responsibility
- Encourage optimal community engagement and involvement

The ongoing process that followed represented an 'action learning' approach where key stakeholders varied and evolved over the development phase. The initial Workshop had been attended by representatives from the following: BNPCA service providers: Banyule Community Health, Nillumbik Community Health, NEAMI, Banyule City Council, Nillumbik Shire Council, Vision Australia, Kinect Australia, WHIN, BECC, Kalparrin and Diamond Valley Learning Centre, some of whom have not continued to actively participate in the planning process. Those organisations either returning representatives or new contributors to the latter stages have been Austin, LaTrobe Communications Clinic and an Indigenous Services Officer from Centrelink. This process led to the final decision to retain the following agreed priorities for 2006-2009 for the BNPCA:

- **Physical Activity**
- **Mental Wellbeing and Social Connectedness**

It was felt at the time of the initial Planning Workshop in October 2005, that because the majority of member agencies had already been working successfully towards greater coordination and cooperation, it would be of benefit to their moving more strategically towards collaboration, if the selection of priority areas were to remain the same i.e. focus on physical activity and mental health and wellbeing. It was also determined to aim at building upon the advancements made against our two priority areas addressed in our previous plan.

Discussions regarding the specific populations of interest within the above priority areas were ultimately resolved by determining that at the PCP level the target would be "*those at risk of low levels of participation and inclusion*"; with individual agencies deciding for themselves what specific target groups they would focus upon in response to local expressed needs.

According to the Your Health Report 2005 statistics on Victorian Ambulatory Care Sensitive Conditions (ASCS)⁴ the top 5 for Banyule/Nillumbik; are:

	No. of Admissions	Average Bed Days	Total Bed Days
Diabetes complications	1,197	9.53	11,412
Dental Conditions	541	1.12	606
Dehydration & Gastro-enteritis	435	2.11	918
Chronic Pulmonary Disease (CPD).	341	7.78	2,653
Congestive Cardiac Failure	344	5.99	2,059

In addition, both in terms of average bed days and total bed days, the top 3 ACSC's in North West Metropolitan Region (N&WMR) are Diabetes, Chronic Pulmonary Disease and Congestive Cardiac Failure⁵

Given that physical activity is implicated as an adjunct therapy in all the above conditions, there was a strong rationale for selecting physical activity as a priority in a concerted catchment wide approach.

⁴ See Your Health: a Report on the Health of Victorians, DHS Melb. 2005 p.76

⁵ See http://www.health.vic.gov.au/healthstatus/downloads/acsc/acscs0203_northern060505.pdf

However, in recognition of the evidence of the potential for beneficial outcomes (for consumers) being recently reported⁶, it was felt by workshop participants that an integration of physical activity initiatives into programs addressing social connectedness and social isolation was a preferred option for 2006-2009. This view of *physical activity* as a vehicle for enhanced *mental health and wellbeing* through exposure to social support networks and opportunities for social engagement was a key discussion factor for workshop participants.

Health Equity Issues

Many Banyule and Nillumbik residents enjoy relatively high levels of social advantage, (with a 2001 IRSED ranking of 68 and 75 respectively) along with relatively low levels of unemployment. However significant pockets of social and economic disadvantage are experienced across both LGAs. Some areas within Nillumbik Shire are rural in nature and residents are isolated in terms of access to services and limited public transport options.

The Jesuit Social Services study of 1999 indicated that West Heidelberg ranked third across Melbourne and seventh in the state as one of the most disadvantaged localities. This location has also been recently identified as the first Neighbourhood Renewal site within this catchment. This project is currently forming its governance structure through consultation with residents and other stakeholders. One of the identified areas that will be part of the structure is the formation of a Health and Wellbeing Working Group. It is likely that the BNPCA will participate in this Group. Also Banyule Community Health Service (BCHS) and BNPCA have received funding to implement the Early Intervention into Chronic Disease initiative in Banyule. In addition Banyule has a sizable and increasing indigenous population. This group is twice as likely to comprise single parent families and often experience almost three times the rate of unemployment than their non-aboriginal counterparts.⁷

Agreed Goals & Objectives

Based on the above process and the experience of the BNPCA member agencies, the following goals and objectives were established using a capacity building framework:

Physical Activity

Goal 1: *To improve the health and wellbeing, (through increased physical activity) of residents of Banyule and Nillumbik.*

Objective 1: *“There will be increased opportunities for people experiencing lower levels of, or barriers to their, participation in Physical Activity”.*

Includes:

- To raise awareness of how to get involved in physical activity
- To determine barriers to participation and improve access to physical activity opportunities
- To ensure the provision of improved infrastructure to support increased opportunities for physical activity

Objective 2: *“There will be strong sustainable links built between member organisations with an increased capacity to organise, plan, deliver and evaluate effective physical activity interventions”.*

⁶ E.g. See www.psychologymatters.org/exercise.html

⁷ See Banyule Municipal Population Snapshot 2006. Briefing paper prepared by Social Planning Unit BCC

Mental Health and Wellbeing:

Goal 2: “To improve emotional health and wellbeing of people living in Banyule and Nillumbik who are at risk of social isolation”.

Objective 1: *“There will be increased opportunities for community members to enhance their skills, knowledge and understanding of ways to improve/promote emotional health and wellbeing”.*

Objective 2: *“There will be increased opportunities for socially isolated members of our community to participate in social and community based activities”.*

Objective 3: *“There will be strong, sustainable links built between member organisations with an increased capacity to organise, plan, deliver and evaluate interventions that reduce social isolation”.*

SOLUTION GENERATION

Mix of interventions

Health Promotion Working Group Members	
Agency	Partner Representative
Austin Health (Austin)	Sara Chidgey / Taya Shevchenko
Austin Health CAMHS (Austin CAMHS)	Anne Boscutti / Barbara Collard
Banyule Community Health Service (BCHS)	Eileen Holbery / Rhonda Nelson / Melissa Bryan
Banyule City Council (BCC)	Helen Clough
Bundoora Extended Care Centre (BECC)	Helen Corbett
Centrelink Indigenous Service (Centrelink)	Alana Byrnes / Olly Phillips
Diamond Valley Learning Centre (DVLC)	Julie Johnson
La Trobe Communication Centre (LCC)	Kathryn Harker
La Trobe University	Rae Walker
Nillumbik Community Health Service (NCHS)	Amanda Murphy / Susan Rennie
Nillumbik Shire Council (NSC)	Carolyn Hughes / Chris Payne
NEAMI North East (NEAMI)	Joe Cassar
DHS North West Region (N&WMR)	Stephanie McAdam
Women's Health in the North (WHIN)	Wei Leng Kwok

The remainder of this IHP plan is presented in two parts:

Mix of Interventions which essentially provides a summary of the key actions being undertaken by each member Agency within each Priority area. The following catchment plan sets out the key actions proposed within each objective and intervention category, with the agency taking primary responsibility being readily identifiable from the above agency codes.

Capacity Building Initiatives which summarises the planned actions agreed to by the partnership itself to facilitate the effective implementation of the plan.

As detailed in the catchment planning process previously outlined, a concerted effort was made to achieve the widest possible mix of interventions across the catchment. However as the Catchment Plan indicates there is little within the Screening and Individual Risk Assessment category. This is best explained as being more reflective of the fact that many of our key agency members are redirecting their focus towards a more upstream approach in their IHP planning efforts, rather than any lack of on-going activity in this category.

There will be a need (in the next 12 months) to engage the Health and Wellbeing Working Group of the West Heidelberg Neighbourhood Renewal Project along with the need to include Division of General Practice, Housing, Schools & District Nursing Service representatives in some proposed special issue steering groups.

2006-2009 Integrated Health Promotion Catchment Plan

PRIORITY 1: Physical Activity

Objective 1	Screening & Risk Ass.	Health Ed. & Skill Dev.	Soc Mark & Health Inf.	Community Action	Settings & Sup. Env.
<p>There will be increased opportunities for people experiencing lower levels of, or barriers to their, participation in Physical Activity</p> <p>Includes: To raise awareness of how to get involved in physical activity</p> <p>To determine barriers to participation and improve access to physical activity opportunities</p> <p>To ensure the provision of improved infrastructure to support increased opportunities for physical activity</p>	<p>Implement Early Intervention in Chronic Disease (“Health for Life”) initiative to provide appropriate PA options for identified clients BCHS</p>	<p>Launch a Health and Fitness program specifically for young people at the Olympic Leisure Centre and the Ivanhoe Aquatic and Fitness Centre BCC</p> <p>Extend through Leisure services Living Longer, Living Stronger and Prime Time initiated options available for the community BCC/NSC</p> <p>MetroActive New activities to include:</p> <ul style="list-style-type: none"> • 10,000 Steps • Themed/guided walks • Beginner bike rides • Support to Walking Groups NSC <p>Implement “Early Intervention in Chronic Disease” initiative to provide appropriate PA options for identified clients BCHS</p>	<p>Conduct Older Adults information EXPO. BCC</p> <p>Increase the number of primary and secondary school students travelling to and from school by active means NCHS/NSC</p> <p>Implement “Early Intervention in Chronic Disease” initiative to provide appropriate PA options for identified clients BCHS</p> <p>Encourage physical activity and participation in recreation options through the Access for All Abilities program NSC/BCC</p> <p>Encourage physical activity and participation in community recreation options through Model of care for Healthy Living – BECC program</p> <p>Upgrade and expand the Get Set Go Guide, an electronic physical activity directory for Banyule and Nillumbik residents” BCC/NSC/BNPCA</p>	<p>Increase the number of primary and secondary school students travelling to and from school by active means NCHS / NSC</p> <p>Encourage and promote alternatives to reliance on the use of private cars for transport BCC/NSC/NCHS</p> <p>Implement the MetroAccess project, to foster ‘environments for health’ that are more inclusive of people with a disability NSC/BCC</p> <p>Develop and implement a workplace based physical activity program BECC</p> <p>Support Neighbourhood Renewal Project Strategies BCC/BCHS/BNPCA</p> <p>Support and enable a consultative mechanism for ATSI consumers, particularly families Centrelink/BCC/BNPCA</p>	<p>Continue to support the Walking School Bus Initiatives NCHS/NSC</p> <p>Encourage and promote alternatives to reliance on the use of private cars for transport (TravelSmart) BCC/NSC/NCHS</p> <p>Implement the MetroAccess project, to foster ‘environments for health’ that are more inclusive of people with a disability NSC/BCC</p> <p>Local businesses to develop and implement a workplace based physical activity program NCHS</p> <p>Coordinate a range of capital works to accommodate better open space provision NSC</p> <p>Expand the range of recreation activities focusing on the needs of people with disabilities at Olympic Leisure Centre. BCC</p> <p>Support Neighbourhood Renewal Project Strategies BCC/BCHS/BNPCA</p>

2006-2009 Integrated Health Promotion Catchment Plan

PRIORITY 1: Physical Activity Cont.

Objective 1 Cont	Screening & Risk Ass	Health Ed. & Skill Dev.	Soc Mark & Health Inf.	Community Action	Settings & Sup. Env.
<p>There will be increased opportunities for people experiencing lower levels of, or barriers to their, participation in Physical Activity</p> <p>Includes: To raise awareness of how to get involved in physical activity</p> <p>To determine barriers to participation and improve access to physical activity opportunities</p> <p>To ensure the provision of improved infrastructure to support increased opportunities for physical activity</p>				<p>Consult with the community to review and refocus Banyule's Recreation Strategy and develop a 5 year plan to meet changing needs and promote active lifestyles and community wellbeing BCC</p> <p>Undertake public consultation on health and well-being issues of significance within local communities NSC</p> <p>Conduct staff education sessions on diverse cultural communities within Banyule BCC</p> <p>Produce new Recreation Trails Brochure NSC</p> <p>Respond in a planned and programmatic way to the health and wellbeing needs of women across the region WHIN</p>	<p>Support organised sporting clubs to provide a range of recreational options to the community by providing and maintaining sporting facilities NSC</p> <p>Continue to support the advisory group to assist with implementation of the Recreation Trails Strategy NSC</p> <p>Enhance the accessibility of recreation trails and promote their use to all people, including new users and at-risk groups BCC/NSC (S&SE?)</p> <p>Review the Municipal Bicycle Strategic Statement & Recreation Strategy BCC</p> <p>Develop and maintain safe facilities for walking and cycling across the catchment NSC</p> <p>Implement Active Aging Policy in Banyule BCC</p> <p>AAA Leisure/Recreation - Staff promoting access to physical activity for people with disabilities BCC</p>

2006-2009 Integrated Health Promotion Catchment Plan
PRIORITY 1: Physical Activity Cont.

Objective 1 Cont	Screening & Risk Ass	Health Ed. & Skill Dev.	Soc Mark & Health Inf.	Community Action	Settings & Sup. Env.
<p>There will be increased opportunities for people experiencing lower levels of, or barriers to their, participation in Physical Activity</p> <p>Includes: To raise awareness of how to get involved in physical activity</p> <p>To determine barriers to participation and improve access to physical activity opportunities</p> <p>To ensure the provision of improved infrastructure to support increased opportunities for physical activity</p>					<p>Implement the objectives of the VicHealth funded Metro-Active project to enhance local Physical Activity (PA) options for the community, especially identified at-risk groups, with a focus on walking and cycling using Nillumbik's Recreation Trails. NSC</p> <p>Conduct Community Walkability Audit at Greensborough Shopping precinct BCC etc.</p> <p>Enhance the accessibility of recreation trails and promote their use to all people, including new users and at-risk groups BCC/NSC</p> <p>Northern Healthy Cities Project Action research on walkability and supportive environments BCC/NSC</p> <p>Provide opportunities for passive and active recreation for the community within the redevelopment of the Malahang Reserve, West Heidelberg BCC.</p>

2006-2009 Integrated Health Promotion Catchment Plan

PRIORITY 2 Mental Well-being & Social Connectedness

Objective	Screening & Risk Ass	Health Ed. & Skill Dev.	Soc Mark & Health Inf.	Community Action	Settings & Sup. Env.
<p>1) There will be increased opportunities for community members to enhance their skills, knowledge and understanding of ways to improve/promote emotional health and wellbeing.</p>	<p>Jointly provide drug & alcohol information and support services to people living in Banyule & Nillumbik - BCHS NEODAS</p> <p>Provide a support service for Banyule and Darebin residents with gambling problems - BCHS</p> <p>Offer treatment and support to women experiencing postnatal depression through the National Post Natal Depression Study - Austin/ NEVDGP/ BCC</p> <p>Enable people with mental health issues in Banyule and Nillumbik to access free treatment and support through the Allied Mental Health Program NEVDGP</p>	<p>Provide a skills training program for community clubs to enhance volunteer management knowledge & expertise in marketing, financial & business management, risk management and disability awareness BCC</p> <p>Improve community mental health literacy with a particular focus on CALD communities WHIN / Centrelink</p> <p>Provide parent training for pre-school/primary school children aimed at preventing or limiting the development of literacy difficulties LCC</p> <p>Implement Phase One of the West Heidelberg Everyday Learning and Living Project for disadvantaged parents and children BCC</p>	<p>Arrange distribution of an awareness raising DVD on the difficulties confronted by people with a mental health diagnosis NEAMI,BCC etc.)</p> <p>Development of a web-based information service for adult stutterers and parents of children who stutter LCC</p>	<p>Actively involve community members in projects and/or processes which contribute to service planning, implementation and review BCHS/BECC/ LCC and with a particular emphasis on rural settings NCHS</p> <p>Increase the % of mothers of pre-school aged children who belong to a new parents group (focus on PND) NCHS</p>	<p>Work with various providers in implementing the Neighbourhood Renewal project for West Heidelberg BCC/ BCHS</p> <p>Enhance the capacity of the primary health and broader service system to respond effectively to the needs of women at risk of mental health issues WHIN</p> <p>Advocate to, support and train sporting and recreation clubs and organisations to accommodate and welcome people with disabilities and to develop inclusive practices BCC</p>
<p>2) There will be increased opps. for socially isolated community members to participate in social and community based activities</p>	<p>Provide a social support group for older Chinese residents of Banyule BCC</p> <p>Provide support services for fathers in Banyule BCC</p>	<p>Switching On Project – a two year performing arts mental health promotion initiative in West Heidelberg involving 4 schools and 7 agencies. BCC/Austin CAMHS/ BCHS</p>	<p>Promote, develop and provide opportunities for older people to socialise and participate in wider community activities BCC/NSC</p>	<p>Support programs for same-sex attracted young people through local and regional partnerships NSC</p>	<p>Increase in the number of opportunities for young people (especially in rural areas) to participate in social, recreational and community programs NCHS</p>

2006-2009 Integrated Health Promotion Catchment Plan

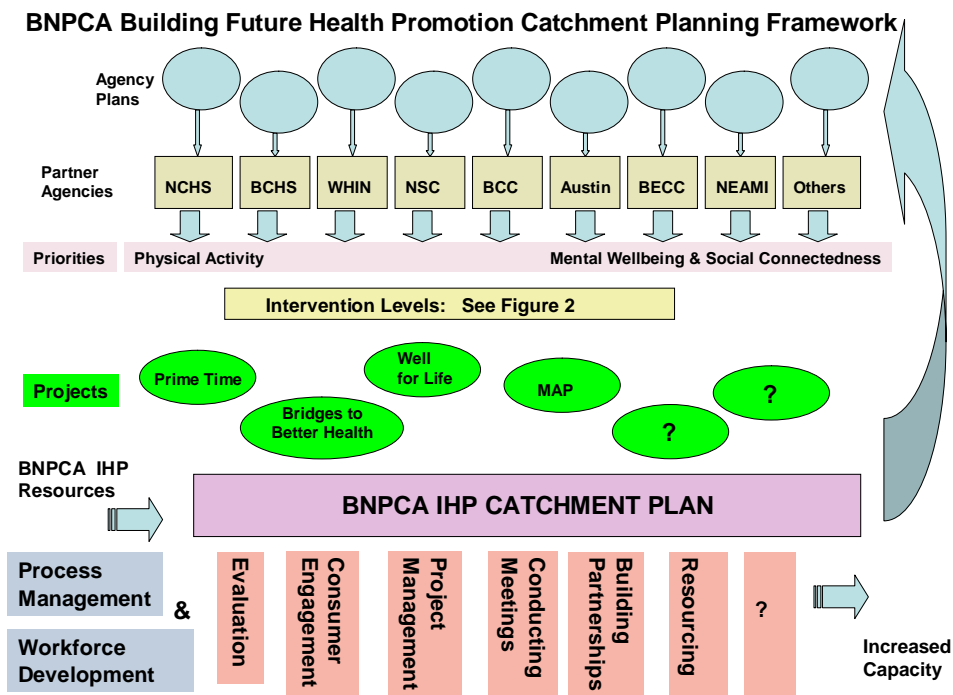
PRIORITY 2 Mental Well-being & Social Connectedness

Objective 2 Cont	Screening & Risk Ass	Health Ed. & Skill Dev.	Soc Mark & Health Inf.	Community Action	Settings & Sup. Env.
<p>There will be increased opportunities for socially isolated members of our community to participate in social and community based activities (Cont.)</p>	<p>Implement programs that improve young people's access to services, support young people's active participation and personal development to strengthen their resilience and improve life skills BCC</p>	<p>Provide a parent training program aimed at preventing and re-mediating communication delay and disorders in pre-school children LCC</p> <p>Conduct programs to provide participants with a better understanding of anxiety and techniques for effective self management NEAMI / BECC</p> <p>In collaboration conduct MOOD programs to provide participants with a better understanding of depression and techniques for effective self-management NEAMI/ NEPMHT, NCHS & BCHS</p>	<p>Promote and develop recreational, social and respite opportunities for people with disabilities and their families BCC</p>	<p>Continue to develop and promote programs to address issues that contribute to young people being at risk and lacking connectedness NSC</p> <p>Provide residents of Hurstbridge with opportunities to participate in street based ecological projects NCHS</p> <p>Conduct staff education sessions on diverse cultural communities within Banyule BCC</p> <p>Promote and provide opportunities for Banyule's older people to socialise and participate in wider community activities BCC/ BCHS</p> <p>Establish pilot recreation programs for older adults and people with disabilities in partnership with service providers BCC</p>	<p>Work with ATSI Communities (and Peak bodies/organisations) to improve access to services, recognition and inclusion within the wider community BCC etc</p> <p>Support and enable a consultative mechanism for ATSI consumers (particularly families) Centrelink</p> <p>Facilitate targeted advocacy programs for specific population groups, including young people, people with disabilities and older people NSC/Centrelink</p>

CAPACITY BUILDING

Organisational Development

The catchment planning framework and model as described below outlines a continuous planning process that will support the integration of organisational IHP planning amongst key member agencies such as local government MPHP and Community and Women's Health IHP planning.



Each member agency contributes their own plans and data sets to aid in the development of specific evidence based priority areas. An analysis is then undertaken of key activities of member agencies within the agreed priority areas (using the 5 key intervention levels), in order to identify the focus of each intervention and those areas where there are evident gaps and duplication. Individual agencies are then able to identify specific interventions and seek BNPCA assistance in implementing projects which will address priority areas and strategic directions. These will then feed into the catchment plan and enable the BNPCA IHP resources to be effectively allocated across a range of workforce development and capacity building strategies aimed at supporting the successful implementation of priority issues across the catchment area.

Whilst not all agencies have it within their mandate to contribute directly to all levels of strategy, each agency supports the necessity to operate collaboratively and agrees to contribute to the development of the overall catchment plan. The purpose of the catchment plan is to clarify and coordinate the different contributions that each member makes in relation to each identified priority area. When combined together, the activities of the BNPCA membership will address the widest possible range of strategies required to successfully develop, implement and evaluate integrated health promotion activities across the catchment.

The on-going application and review of the above catchment planning process will be a key priority over the next 12 months. The future IHP structure will be further developed over the next twelve months, although it is envisaged that it will consist of quarterly review Forums along with the two priority Networks and a number of ad hoc Steering Groups to oversight

particular capacity building elements of the Plan. There will also be a requirement to ensure that the priority Networks are robust in addressing planning and implementation requirements for each agreed priority. (See attached Implementation Plan 2006-2007)

Partnerships

Building capacity requires action from within organisations as well as between them. The BNPCA has recently implemented a new structure which envisages an overhaul of the IHP WG. The likely revision of the Working Group into a quarterly forum format will necessitate a greater emphasis on maintaining ongoing communications. There is a need to support the “Early Intervention in Chronic Disease” initiative to facilitate the application of best practice Self Management options and a number of identifiable initiatives that will affect the manner in which the BNPCA IHP membership is expanded to further facilitate inter-sectoral collaboration. A key aim is to expand the inclusion and participation (in BNPCA IHP planning) of representatives from our new Neighbourhood Renewal site and other relevant agencies across the catchment. We will also aim to be flexible enough to encourage the cross-sector cooperation with other relevant bodies (e.g. Education, Housing, etc.) as required, in order to facilitate the successful implementation of key projects. (See attached Implementation Plan 2006-2007)

Leadership

Leadership also incorporates the provision of the qualities and resources that can be applied in various settings to build the leadership skills of others. Within the BNPCA, Leadership is achieved through the ongoing development and implementation of the Catchment Planning Framework and the provision of support for collaborative efforts identified in the mix of interventions via the agreed process (as outlined above), being implemented. A key focus will be the provision of opportunities to better integrate strategies between health and non-health sectors through fostering dialogue and discussion. There will also be a significant component in promoting the revised Get, Set, Go Guide and developing sustainability for the Well for Life and Prime Time initiatives. (See attached Implementation Plan 2006-2007)

Workforce Development

Opportunities will be provided for relevant agencies to extend their knowledge and skills in developing evidence-based / best practice interventions which aim to improve the health and wellbeing of residents of Banyule and Nillumbik through increased participation in physical activity and social connectedness initiatives. An early focus will be upon the provision of opportunities to enhance skills in the evaluation of health promotion initiatives and enhancing skills in relation to consumer engagement. (See attached Implementation Plan 2006-2007)

Resources

There are a number of critical resourcing tasks that are immediately apparent and will be necessary to implement and sustain the elements of this plan. Provision of support to the review and launch of the Get, Set, Go Guide will be a key element along with increased data sourcing and webpage development. (See attached Implementation Plan 2006-2007)

BNPCA 2006-2007 Integrated Health Promotion Implementation Plan

ORGANISATIONAL DEVELOPMENT

Objectives	Strategies	Reach	Timelines	Achievement Indicators
Priority 1 & 2 There will be strong sustainable links built between member organisations to support increased capacity to organise, plan, deliver and evaluate effective physical activity and social connectedness interventions.	Ensure the ongoing functioning of the Physical Activity Network	All BNPCA member agencies and relevant groups	June 07	PAN will <ul style="list-style-type: none"> • Collate info on barriers to participation • Identify service gaps • Seek out and action appropriate funding opportunities to reduce barriers
	Establish and oversee the ongoing functioning of an Emotional Wellbeing and Social Connection Network	All BNPCA member agencies and relevant groups	April 07 June 07 & ongoing	Network established and Terms of Reference developed Commence process to identify barriers and gaps
	To ensure that an appropriate structure is in place to monitor the ongoing implementation of the catchment Plan.	All BNPCA member agencies and relevant groups	Dec. 2006 June 07 & ongoing	New Terms of Reference are established Participation/ membership of IHP is aligned with priority Networks Effective monitoring and review processes are in place to facilitate future best practice catchment planning

BNPCA 2006-2007 Integrated Health Promotion Implementation Plan (Cont.)

PARTNERSHIPS

Objectives	Strategies	Reach	Timelines	Achievement Indicators
Priority 1 & 2 There will be strong sustainable links built between member organisations supporting an increased capacity to organise, plan, deliver and evaluate effective physical activity and social connectedness interventions.	With NEVDGP support the expansion of the Lifescripts Initiative across the catchment	All BNPCA member agencies and relevant groups	Jan/Feb 2007	20% of GPs utilising Lifescripts application
	Further develop linkages to Municipal Public Health planning processes to facilitate integration and best practice within the region	All BNPCA member agencies and relevant groups	July 2007 & ongoing	Increased number of BNPCA members involved and contributing to the planning processes of both municipalities
	Develop an engagement strategy and appropriate linkages to the West Heidelberg Neighbourhood Renewal Project Team	All BNPCA member agencies	July 2007 & ongoing	There will be cross membership of representatives of BNPCA IHP and West Heidelberg Health and Wellbeing Project
	Provide support to relevant Healthy and Active Living and MetroActive programs in the catchment	BNPCA relevant member agencies	July 2007 & ongoing	Increased number of BNPCA members involved and contributing to the planning processes of both municipalities
	Contribute to the future planning processes of new members e.g. Diamond Valley Learning Centre	BNPCA relevant member agencies	July 2007 & ongoing	Increased number of new non-health sector groups whose planning processes are integrated with BNPCA catchment plans
Support “Early Intervention in Chronic Disease” initiative to facilitate the application of best practice Self Management options	All BNPCA member agencies	All BNPCA member agencies	July 2007 & ongoing	Increased number of self management options being made available to the community

BNPCA 2006-2007 Integrated Health Promotion Implementation Plan (Cont.)

LEADERSHIP

Objectives	Strategies	Reach	Timelines	Achievement Indicators
<p>Priority 1 & 2 There will be strong sustainable links built between member organisations supporting an increased capacity to organise, plan, deliver and evaluate effective physical activity and social connectedness interventions.</p>	<p>Build agencies opportunities for intergenerational and cross cultural interaction around physical activity, emotional wellbeing and social inclusion which can also improve community safety, inclusiveness of diversity and lifelong learning</p> <p>Develop and support a sustainability plan for Prime Time initiatives and encourage the on-going inclusion of Well For Life program messages into all HACC PAG sessions</p>	<p>All BNPCA agencies D V Learning Centre & Centrelink</p> <p>BNPCA, BCC/ NCHS / BLFM/ AUSTIN/ BECC & YMCA</p>	<p>July 07</p> <p>May 07</p> <p>March 07</p>	<p>Six local Learning Centres and other relevant non-health services will:</p> <ul style="list-style-type: none"> • Attend relevant Network meetings • Partner in relevant submissions, and Participate in project management arrangements <p>Prime Time initiatives continue beyond current funding</p> <p>Well for Life becomes an integral part of HACC PAG services across the catchment as assessed through a program audit</p>

BNPCA 2006-2007 Integrated Health Promotion Implementation Plan (Cont.)

WORKFORCE DEVELOPMENT

Objectives	Strategies	Reach	Timelines	Achievement Indicators
<p>Priority 1 & 2 There will be strong sustainable links built between member organisations supporting an increased capacity to organise, plan, deliver and evaluate effective physical activity and social connectedness interventions.</p>	<p>Provide opportunities that enhance the theoretical knowledge and awareness of evidence-based programs in promoting physical activity and addressing issues relevant to the 'improved emotional health, wellbeing and social connectedness of people living in Banyule and Nillumbik</p> <p>Develop, conduct and review a .5 day Introduction to IHP training option for staff of member agencies</p> <p>Provide capacity building and professional development workshop on evaluating health promotion initiatives</p> <p>Undertake a Literature review on evaluation tools and techniques for BNPCA website</p> <p>In conjunction with the Health Issues Centre to provide workshop opportunities for agencies to enhance their knowledge and understanding of Consumer Engagement best practice techniques</p>	<p>All BNPCA member agencies and relevant groups</p> <p>All BNPCA member agencies and relevant groups</p> <p>All BNPCA member agencies and relevant groups</p> <p>All BNPCA member agencies and relevant groups</p> <p>All BNPCA member agencies and relevant groups</p>	<p>June 07 then ongoing review</p> <p>July 07</p> <p>July 07</p> <p>Dec 07</p> <p>July 07</p> <p>Dec 07</p>	<p>20% of member agencies will access resources on gathering and using evidence based information in their planning process</p> <p>Effectiveness feedback from members is obtained</p> <p>20% of relevant member agency staff will have access to basic IHP training</p> <p>20% of relevant member agency staff will have access to IHP Evaluation training</p> <p>80% agencies access the resource on evaluation planning and implementation as determined by Agency survey</p> <p>Workshop outline developed and planning commenced 20% of relevant member agency staff will attend training</p>

BNPCA 2006-2007 Integrated Health Promotion Implementation Plan (Cont.)

RESOURCES

Objectives	Strategies	Reach	Timelines	Achievement Indicators
<p>Priority 1 & 2 There will be strong sustainable links built between member organisations supporting an increased capacity to organise, plan, deliver and evaluate effective physical activity and social connectedness interventions.</p>	Investigate and prepare a submission for the BNPCA to 'buy into' the QIPPS system	All BNPCA member agencies	March 2007	Submission accepted by Strategic Partnership Group and QIPPS 'buy in' achieved
	Collect collate and disseminate details of barriers being identified by member agencies	All BNPCA member agencies	July 2007 & ongoing	Process for data collection established, data gathered and disseminated across the catchment
	Support and provide necessary resources to develop, launch and promote a more extensive version of the Get, Set, Go Guide	All BNPCA member agencies	July 2007	Revised Get, Set, Go Guide is launched and made accessible through local libraries and Neighbourhood Houses
	Further develop the BNPCA Web content as a resource base on physical activity and social connectedness	All BNPCA member agencies	July 2007 & ongoing	60% of BNPCA members are utilising the Website IHP priority resources as determined by agency survey
	Ensure the availability and use of information via BNPCA (eg. health status, risk factors, national goals and targets, literature reviews, information about effective practice) to support health promotion action	All BNPCA member agencies	July 2007	20% of members are utilising this information via BNPCA website Information is regularly updated
	Develop an evaluation framework and tools to measure changes achieved across the catchment	All BNPCA member agencies	July 2007	PAN & SC Networks using these items and providing feedback on progress and necessary modification
	Develop an equity based data set for Banyule & Nillumbik to assist member agencies in planning health promotion interventions to address priority areas	All BNPCA member agencies	July 2007 & ongoing	Planned interventions reflect a focus on population and health equity issues

Resources - PCP IHP Catchment Resource Summary

Estimated Integrated Health Promotion (IHP) PCP resource allocation

<i>Capacity building components</i>	PCP IHP Funding/Resources	Member Contributions
Partnership Development	\$ 5,661 (10% of IHP Officer time)	?
Leadership	\$ 11,322 (20% of IHP Officer time)	?
Organisational development	\$ 14,152 (25% of IHP Officer time)	?
Planning for evaluation & Dissemination	\$ 8,491 (15% of IHP Officer time)	?
Workforce development	\$ 16, 983 (30% of IHP Officer time)	?
Total PCP Resource/Budget Allocation	\$ 56,609	?

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

Additional Integrated Health Promotion Resources

<i>Funding source/project</i>	Links to Catchment Priority	Funding
Seniors Go for your Life funding to April 07	Prime Time project encouraging physical activity amongst disadvantaged 50+	\$20,000
Well for Life funding	Better health outcomes for PAG clients through physical activity	\$16,000
TOTALS		\$36,000

PLANNING FOR QUALITY - EVALUATION AND DISSEMINATION

The primary aim here is to build a generalised capability among partner organisations and the community which will enable all to tackle any issue in a manner that brings mutually beneficial outcomes. Although capacity-building is an exciting and 'cutting edge' field its introduction into health promotion is still relatively new and there is little accumulated knowledge to provide succinct evidence or performance based quality criteria. We recognise the need for this "invisible" side of health promotion to be made more visible. Evaluation will be a major focus both in terms of determining how the various projects included in our Catchment Plan are progressing towards achieving their objectives and determining whether the BNPCA planned capacity building interventions/strategies have been successfully implemented.

In order to achieve the former a regular Forum for peer review will be established under the auspices of the Integrated Health Promotion Working Group (and its priority Networks), to assist the process of capturing even the unintended impacts and facilitate the dissemination of key learning's. The development of appropriate project evaluation tools will be initially undertaken by each priority Network group which will seek to incorporate a mix of qualitative and quantitative material. These Networks will also gather information on barriers being experienced and identify appropriate mechanisms to support early intervention options. An Evaluation Steering Group will be established to guide the preparation of a literature review on Evaluation which will be disseminated via the BNPCA website. It will also provide the focal point for those Workforce Development initiatives implemented to enhance overall Evaluation skills across the partnership.

In the case of the latter a heavy emphasis during year one, will be placed on the provision of knowledge and skill building opportunities for staff within our member agencies. Pre and post evaluations will be conducted to assess skill transfer thereby forming the core of this evaluation. In addition usage will be made of council community surveys and a regular administration of either the VicHealth Partnership Analysis Tool or the NSW Checklist for Assessing the Strength of a Coalition will be undertaken across all levels of the Alliance.

Finally the Community Health Plan reporting process itself, (through the CHPIA evaluation report July 2007), will also facilitate the preparation and dissemination of outcome reports on the following:

- the level of collaboration that the partnership has developed
- critical success factors and barriers to the Plan's implementation
- determining future allocation of capacity building resources.

APPLYING AN INTEGRATED DISEASE MANAGEMENT 'LENS' TO IHP PLANNING

Diabetes and mental health issues are by far the major contributors to poor health outcomes across the catchment. Increased levels of physical activity and social connection have been reported as having significant impacts in terms of early intervention on both. This plan aims to identify major barriers to participation and inclusion and develop strategies to address them over the next three years. Both local councils are taking major initiatives in building the necessary infrastructure to support increasingly positive health outcomes. Particular disadvantaged groups will be addressed through BNPCA involvement in both neighbourhood renewal initiatives and local council activities within the ATSI, youth and aged populations. Women's Health in the North will continue to contribute to a greater understanding of the impact of gender on women's health status across the region. The 'Health for Life' project coupled with the expressed desire to incorporate newer partnerships and expand member networks should greatly facilitate a more holistic consideration of the breadth of issues to be addressed. As noted earlier the action learning process and the framework devised for developing the catchment plan has helped to clarify, for many smaller member agencies, the means by which they could consolidate their initiatives to achieve a wider population impact.

Portfolio 3: Service Coordination

CONTEXT

The Better Access to Service strategy, introduced 5 years ago sets out a framework which aims to place the consumer at the centre of service delivery and to ensure that they have access to the services they need, as well as opportunities for early intervention, health promotion and improved health and care outcomes; this is referred to as Service Coordination. The BNPCA has had a diverse range of agencies that have been working towards improved Service Coordination across the catchment. The range of agencies represented in this endeavour include: acute and sub-acute hospitals, community health services, local government, district nursing, Division of GP's, and other non-Government agencies including smaller regional services. Each agency has determined for itself the most suitable model to implement the Service Coordination process. There has been extensive work undertaken including: embedding the SCTT into agency procedures, the development of an Interagency Service Coordination Protocol Manual for BNPCA members, the introduction and increased use of an eReferral system, and in some cases organisation structural changes to accommodate implementation of Service Coordination.

VISION

To improve consumers' health and well being outcomes, by ensuring their access to information and the services they require in a timely manner avoiding unnecessary barriers or duplication.

ACHIEVING THE VISION

The following Service Coordination goals have been set for the next three years:

Goal 1 Maintain quality practice in Service Coordination

Goal 2 Continue to encourage GP participation in Service Coordination

Goal 3 Introduce 'new sectors' to Service Coordination

Goal 4 Ensure information systems are appropriate to support quality practice

ACHIEVING THE GOALS – SERVICE COORDINATION

Goal 1 Maintain quality practice in Service Coordination		
Objectives	Strategies/Interventions	Achievement Indicators
1.1 Continue to support quality practice in established Service Coordination agencies	<p>Year 1 Service Coordination Working Group (SCWG) reviews TOR and meets bi-monthly for support and issues discussion</p> <p>Compare BNPCA Agencies Service Coordination practice (BNPCA Interagency Protocol Manual) with the SCTT 2006 Guidelines and Victorian Service Coordination Practice Manual</p> <p>Service Coordination Practitioners Network meet 4 times a year</p> <p>Year 2 Service Coordination Working Group reviews TOR and continues to work on SC issues</p> <p>Develop local Protocols as necessary following comparison of Service Coordination practice</p> <p>Service Coordination Practitioners Network TOR reviewed and combines with NCM PCP</p> <p>Contribute to SCTT Review</p> <p>Year 3 Service Coordination Working Group reviews TOR Implement local Protocols</p>	<p>Key agencies meet bi-monthly to discuss Service Coordination issues and to support SC practice</p> <p>Differences between BNPCA Service Coordination practice and Statewide practice standards are highlighted and discussed</p> <p>SC Practitioners from at least 8 agencies meet for support and to discuss SC issues</p> <p>Key agencies meet regularly to discuss Service Coordination issues and to support SC practice</p> <p>BNPCA Agencies work together to develop necessary local protocols</p> <p>SC Practitioners from BNPCA & NCM PCP meet together</p> <p>BNPCA make a submission to the SCTT Review based on their experience</p> <p>Key agencies meet regularly to discuss Service Coordination issues and to support SC practice Agreed local processes are evident in Service Coordination practice across key BNPCA agencies</p>
1.2 Ensure adequate information about Services is available to enable appropriate referrals for consumers	<p>Year 1 Encourage agencies to contribute accurate information to the Human Services Directory (HSD)</p> <p>Advocate for DHS to correct ongoing concerns about the HSD</p>	<p>8 key BNPCA agencies add or review the information on HSD relating to their service</p> <p>BNPCA agency concerns about HSD are raised with DHS and addressed</p>

	<p>Year 2 Encourage agencies to update information on the HSD</p> <p>Year 3 Encourage agencies to update information on the HSD</p>	<p>12 key BNPCA agencies add or update the information on HSD relating to their service</p> <p>15 BNPCA agencies add or update the information on HSD relating to their service</p>
<p>1.3 Improve Care Planning for consumers with complex needs and multiple agency involvement</p>	<p>Year 1 Support further Regional initiatives to implement Care Planning Protocol</p> <p>Commence BNPCA Care Planning Steering Group to consider local implementation</p> <p>EliCD GP Liaison Worker works with Banyule GPs with patients in the EliCD initiative to improve Care Planning</p> <p>Meet with NCC Project Worker to ensure the learning's of the NCC Project on Care Planning can be incorporated in the Steering Group workplan</p> <p>Year 2 BNPCA Care Planning Steering Group to make recommendations to SC WG about local implementation</p> <p>Implement Care Planning across BNPCA</p> <p>Year 3 Consolidate Care Planning practice across BNPCA for clients with complex needs and multi agency involvement</p>	<p>Agreed Regional approach to Care Planning developed</p> <p>Local implementation issues raised, and workforce development needs identified</p> <p>3 Banyule GPs involved with Care Planning through EliCD initiative</p> <p>Identify issues and learnings from NCC about Care Planning and incorporate in Care Planning workforce development</p> <p>Local implementation plan developed</p> <p>Implementation of Care Planning commenced and at least 5 key agencies participating</p> <p>Increase the number of clients involved in Care Planning and the number of participating agencies</p>
<p>1.4 Support agencies with the introduction of Assessment Frameworks</p>	<p>Year 1 Work with HACC Assessment Agencies with the introduction of the HACC Assessment Framework</p> <p>Year 2 Commence a BNPCA Assessment Framework Steering Group</p> <p>Year 3 Roll out further Assessment Frameworks as they are developed</p>	<p>Support HACC Assessment agencies in the catchment and other HACC agencies to understand implications of the Framework</p> <p>Wider appreciation of Assessment Frameworks by key BNPCA agencies and local implications</p> <p>Other Assessment Frameworks are introduced to Service Coordination practice</p>

Goal 2 Continue to encourage GP participation in Service Coordination

Objectives	Strategies/Interventions	Estimated Impact
<p>2.1 Increase GPs awareness of primary health care services</p>	<p>Year 1 Each month a different agency to be highlighted on NEVDGP eNewsletter and provide links to agency website</p> <p>Continuation of visits to GPs about the Lifescrpts program and referral pathways to sub-acute and primary health care services</p> <p>Provide joint educational opportunities for GPs, practice staff and primary health care staff on Motivational Interviewing</p> <p>Year 2 Encourage GPs to use electronic service directories</p> <p>Explore opportunities to communicate with Practice Nurses and Managers about primary health care services</p> <p>Year 3 Build on work being undertaken in Portfolio 4 – ICDM</p>	<p>The indicators of progress for this goal will be:</p> <ul style="list-style-type: none"> • Increase in the number enquiries and referrals from GPs • Increase in the number of referrals received on the Victorian Statewide Referral Form • Interested GPs registered and using the s2s eReferral system • Feedback provided to GPs is reviewed and improved • An Increase in the number of GPs participating in Care Planning
<p>2.2 Support and encourage GPs to use the Victorian Statewide Referral (VSR) Form</p>	<p>Year 1 Provide instructions to download form and populate it with patient data</p> <p>Consistent requests from agencies for GPs to use the VSR form</p> <p>EliCD using VSR form for referrals to their initiative</p> <p>Year 2 & Year 3 Agencies continue to request referrals on VSR Form</p>	<p>Increase by 5% in number of GPs using the form to refer patients to key member agencies</p> <p>Further 5% increase in number of referrals from GPs on form each year</p>
<p>2.3 Support GP registration to the s2s eReferral system</p>	<p>Year 1 Offer free registration to any GP interested in using the s2s eReferral system at BNPCA expense</p> <p>Provide training to GP and practice staff</p>	<p>3 GP practices to be registered to s2s eReferral system</p>

	<p>Year 2 Offer free registration to any GP interested in using the s2s eReferral system at BNPCA expense</p> <p>Provide training to GP and practice staff</p> <p>Year 3 Offer free registration to any GP interested in using the s2s eReferral system at BNPCA expense</p> <p>Provide training to GP and practice staff</p>	<p>Further 3 GP practices to be registered</p> <p>Further 3 GP practices to be registered</p>
<p>2.4 Improve feedback provided to GPs after referral and during Care Planning process</p>	<p>Year 1 Map feedback currently provided to GPs after referral and during Care Planning process</p> <p>Work with NEVDGP to establish GP requirements on feedback</p> <p>Year 2 Develop protocol to outline feedback requirements and processes</p> <p>Year 3 Implement protocol</p>	<p>Feedback provided to GPs is clearly understood</p> <p>GP requirements on feedback researched and described</p> <p>Protocol established and accepted by BNPCA agencies</p> <p>Protocol is put into practice and feedback from GPs via NEVDGP is positive</p>

Goal 3 Introduce 'new sectors' to Service Coordination		
Objectives	Strategies/Interventions	Estimated Impact
3.1 Provide suitable induction to Service Coordination practice, processes, protocols and systems for new sectors	<p>Year 1 Commence introduction of SC in Palliative Care, Drug & Alcohol and Mental Health Services</p> <p>Approach 3 local private hospitals about participating in SC</p> <p>Year 2 Commence introduction of SC in Disability services and Family Services</p> <p>Assist interested Private Hospitals to understand SC and what it would mean for their organisation to join initiative</p> <p>Year 3 Follow up with agencies from the above sectors they may not have been involved in initial induction</p>	<p>Identified new sectors begin to explore benefits and challenges of Service Coordination</p> <p>Local private hospitals provide an indication of interest to participate in Service Coordination</p> <p>Identified new sectors and private hospitals begin to explore benefits and challenges of Service Coordination</p> <p>2 Private Hospitals to become participating members of BNPCA</p> <p>Additional agencies explore the benefits and challenges of Service Coordination for them</p>
3.2 Support agencies with the introduction of Service Coordination into their organisation	<p>Year 1 Concentrate on assisting Palliative Care Agencies to embed SC in agency practices</p> <p>Encourage Palliative Care agency representatives to participate in BNPCA activities</p> <p>Year 2 Concentrate on assisting Drug & Alcohol and Mental Health Services to embed SC in agency practices</p> <p>Encourage Drug & Alcohol and Mental Health Services agency representatives to participate in BNPCA activities</p> <p>Year 3 Concentrate on assisting disability and family services embed SC in agency practices</p> <p>Encourage disability and family services agency representatives to participate in BNPCA activities</p>	<p>2 Palliative Care agencies to commence SC Practice</p> <p>2 Drug & Alcohol and 2 Mental Health Services commence SC practice</p> <p>2 Disability and 2 Family Service agencies commence SC practice</p>

Goal 4 Ensure information systems are appropriate to support quality practice		
Objectives	Strategies/Interventions	Estimated Impact
4.1 Support registered agencies to increase use of the s2s eReferral system within and between agencies	<p>Year 1 Support the transfer of contracts to individual agencies in Jan 2007</p> <p>Participate in s2s eReferral User Group</p> <p>Increase use of s2s eReferral system in catchment</p> <p>Continue to advocate for interoperability between eReferral systems</p> <p>Year 2 Increase use of s2s eReferral system in catchment</p> <p>Year 3 Increase use of s2s eReferral system in catchment</p>	<p>Registered key agencies sign individual contracts with Infoxchange to continue with s2s eReferral system</p> <p>S2s eReferral User Group continues so that registered agencies can be represented</p> <p>Increase to 35 eReferrals on average per week and 1 new registered agency</p> <p>Interoperability achieved</p> <p>Increase to 50 eReferrals on average per week and 3 new registered agencies</p> <p>Increase to 80 eReferrals on average per week and 5 new registered agencies</p>
4.2 Provide opportunity for agencies implementing HealthSMART to meet together	<p>Year 1 Commence healthSMART Steering Group for agencies implementing the program to support each other and identify ways it can enhance quality practice</p> <p>Year 2 Continue healthSMART Steering Group and explore impact on other information system processes in catchment</p> <p>Year 3 Difficult to anticipate Strategies this far ahead</p>	<p>HealthSMART agencies have opportunity to discuss program together and enhance quality practice</p> <p>Impact on other information systems, eg eReferral identified</p>
4.3 Continue to address and progress Information, Communication and Technology (ICT) issues as they arise and respond to new opportunities as they present themselves	<p>Year 1 Work with Access Providers to ensure adequate ICT is provided to agencies connected to ICT Network</p> <p>If AP is successful in gaining extra funding, work with them to develop and implement a Project that will enhance current IT communication methods</p> <p>Year 2 Ensure that agencies are getting maximum benefit from ICT Network</p> <p>Year 3 Remain aware of additional ICT opportunities to enhance ICT in member agencies</p>	<p>Adequate ICT is provided to connected agencies</p> <p>Project plan developed and implementation commences</p> <p>Member agencies aware of full capacity of ICT Network</p> <p>New opportunities are considered and applied for</p>

Portfolio 4: Integrated Chronic Disease Management

CONTEXT

During 2001 – 2004 BNPCA auspiced a very successful pilot project called “Take the Pressure Down”; Implementing a Self-Management and Hypertension Program in the Community⁸, which was funded under the Department of Human Services Integrated Disease Management Initiative. The aim of the project was to improve health outcomes and quality of life for consumers with, or at risk of hypertension, in the Banyule and Nillumbik local government areas by developing models of care that promoted:

- Consumer orientation and engagement
- Self management for people with hypertension
- Co-coordinated and planned care based on evidence of best practice and care pathways including engagement of all players
- Early intervention and prevention of hypertension with a health promotion focus on physical activity and awareness of hypertension

The project was evaluated both externally and internally and the reports are available on the BNPCA website as noted below. The key learnings and recommendations were as follows:

- Hypertension is important and so is the terminology
- The diagnosis of hypertension: a missed opportunity for change
- Consumers participation offers a “win, win” for all
- Successful establishment of a community self management program
- Self management education of health professionals is required
- Consumers respond to direct approach
- Centralized coordination proves effective
- General Practitioner engagement is assisted with programs delivered through a Division of GP, linked to financial incentives, targeted towards a “priority” disease, not labeled “self management” and funded on a longer term basis

During the project Nillumbik Community Health Service (NCHS) coordinated the Better Health Self Management (BHSM) programs and successfully trained staff to become Master Trainers for the BHSM programs. NCHS is able to provide leader training within the catchment and provide a focus as a centre for self management expertise and excellence. During the same phase Banyule Community Health Service (BCHS) undertook an internal review of the promotion of self management practices within the service. The outcome of this review was for BCHS to commence a process to integrate the elements of self management such as problem solving and action planning into a number of different programs conducted throughout the service. The internal review provided the impetus for staff to consider changing the treatment focus of some programs to provide a greater emphasis on development of self management skills, to give greater consideration to the role of peer leaders and to introduce new programs. At the same time RDNS were also training staff to run self management classes.

NCHS was funded to continue its coordination of BHSM program for 04/05. Whilst considerable effort was put into this role, it was difficult to recruit people into the programs. However a lot was achieved in capacity building within the catchment around self-management and the BHSM program which has continued to benefit the community.

⁸ “Take the Pressure Down”: Implementing a Self Management and Hypertension Program in the Community, Project findings for the Hypertension Integrated Disease Management Program, BNPCA, 2004. Also published on http://www.bnPCA.org.au/publications/hypertension_project.shtml

Our neighbouring PCP, North Central Metropolitan Primary Care Partnership (NCM PCP) has recently commissioned work to develop a Chronic Disease Care Model for community health that encompasses the continuum of care through:

- Prevention and early detection
- Early intervention
- Providing comprehensive intervention programs that support integration of care across health care sectors
- Promoting self management

BNPCA will use the findings and suggested Implementation Plan from the final report, to inform the Integrated Chronic Disease Management system it designs for the BNPCA catchment.

Since July 2005 when there was no longer an allocated coordinating role for BHSM in the catchment, agencies have become more autonomous in the management of their programs. The challenge has been to utilize the capacity built in the local area as a platform for continuous promotion and incorporation into self-management models of both existing and new programs. NCHS has the capacity to continue to offer training at reasonable cost to other agencies.

Early in 2006 BCHS was funded to implement an Early Intervention in Chronic Disease (EliCD) initiative. A Steering Committee for the initiative was formed consisting of representatives from key agencies in Banyule. Regular EliCD initiative reports are presented to the BNPCA Strategic Partnership Group. The model for this project is now developed and the processes clearly articulated. It will be launched and commence in November as "Health for Life".

Over the next three years a clear strategy for integrated chronic disease management throughout the catchment will be developed by utilizing all that has been learned and gained from the above work in chronic disease programs. Progress in this Portfolio area has clear links with both Service Coordination (SC) and Integrated Health Promotion (IHP). Whilst SC will focus on creating a streamlined and coordinated service system for individuals who fall under its umbrella along with the development of a comprehensive assessment and care planning process; IHP will aim to influence entire populations to enhance their health and wellbeing through various capacity building strategies.

The following ICDM goals and objectives demonstrate that the first year of activity will be directed towards the implementation and commencement of the Banyule EliCD initiative following which there are plans to extend it throughout the catchment. An ICDM Working Group will be formed in the second year to guide this Portfolio area. The goals in this Portfolio will focus on facilitating service system integration and change management.

VISION

To improve the health and wellbeing of people with chronic disease and reduce preventable admission to hospital for this group.

ACHIEVING THE VISION

The following Integrated Chronic Disease Management goals have been agreed to for the next three years:

Goal 1: Develop an integrated approach in the use of self management across the catchment

Goal 2: Ensure that suitable service coordination occurs for clients with chronic disease

Goal 3: Expand the availability of early intervention in chronic disease initiatives across the catchment

ACHIEVING THE GOALS: INTEGRATED CHRONIC DISEASE MANAGEMENT

Goal 1: Develop an integrated approach in the use of self management across the catchment		
Objectives	Strategies / Interventions	Achievement Indicators
1.1 Review and expand self management currently operating within member agencies	<p>Year 1 Undertake a mapping of self-management interventions provided by agencies within the catchment</p> <p>Year 2 Facilitate planning processes to expand self-management interventions within member agencies where gaps were identified in mapping process</p> <p>Year 3 Implementation of the plan developed in Year 2 that will respond to the gaps in self-management interventions</p>	<p>Completion of a mapping exercise detailing the member agencies who have a self management approach to chronic disease</p> <p>Gaps in self management interventions across catchment are identified and plan to address these made</p> <p>Gaps identified in review are addressed</p>
1.2 Define the roles and responsibilities, especially for acute and community health services, in relation to self-management interventions for people with chronic disease	<p>Year 2 Initiate ICDM Working Group to assist with planning the catchment model to address ICDM, including defining roles and responsibilities</p> <p>Year 3 ICDM Working Group continue to oversee implementation of catchment model for ICDM, including defining roles and responsibilities</p> <p>Implement the BNPCA ICDM model</p>	<p>Production of a protocol defining the roles and responsibilities in relation to self-management intervention for people with chronic disease</p> <p>ICDM Working Group commences with representatives from 6 Key agencies</p> <p>Implementation of the ICDM Model defining the roles and responsibilities, in CHSs and Acute services across the catchment</p>

Goal 2: Ensure that suitable service coordination occurs for clients with chronic disease

Objectives	Strategies / Interventions	Achievement Indicators
<p>2.1 Ensure successful implementation of the Better Access to Services framework by member agencies, particularly as it relates to people with chronic disease</p>	<p>Year 1 Review current Service Coordination Practice (Policies, Processes, Protocols & Systems) to ensure it provides suitable pathways for clients with chronic disease</p> <p>Year 2 As per Portfolio 3, continue quality practice in Service Coordination</p> <p>Year 3 As per Portfolio 3, continue quality practice in Service Coordination</p>	<p>Results of review of current SC practice to ensure it provides suitable pathways for clients with chronic disease are available</p>
<p>2.2 Develop a local agreement and systems to identify clients with chronic disease who require comprehensive assessment and cross disciplinary / multi-agency (including GP) care planning, by working with PCP member agencies, particularly GPs</p>	<p>Year 1 Member agencies to participate in workforce development opportunities in assessment and care planning (in Portfolio 3 work plan)</p> <p>EliCD GP Liaison Worker supports GPs with clients in EliCD program to encourage referral and care planning</p> <p>Year 2 Formation of a combined Service Coordination and ICDM Steering Group to work on care planning and comprehensive assessment for clients with chronic disease</p> <p>Production of a local agreement and systems to identify clients with chronic disease who require comprehensive assessment and cross disciplinary / multi agency care planning</p> <p>Year 3 Implement the local agreement and systems across the catchment</p>	<p>5 agencies participate in Care Planning workforce development opportunities HACC agencies participate in Assessment workshops</p> <p>20% of EliCD clients have GPs involved with Care Planning</p> <p>Combined SC and ICDM Steering Group work on developing local agreement and systems to identify clients with chronic disease who require comprehensive assessment and care planning</p> <p>Local agreement and systems finalised</p> <p>Local agreement and systems introduced to 4 key agencies in catchment</p>

Goal 3: Expand the availability of early intervention in chronic disease initiatives across the catchment		
Objectives	Strategies / Interventions	Achievement Indicators
3.1 Continue to support the implementation of the Banyule EliCD Initiative	<p>Year 1 Participation in Banyule EliCD Steering Committee</p> <p>Provision of EliCD GP Liaison Worker</p> <p>Year 2 Continue participation in Banyule EliCD Steering Committee</p> <p>Year 3 Support Banyule EliCD to become embedded in agency practice</p>	<p>Development of a model for Banyule EliCD with support from Steering Committee, including processes and tools Commencement of Banyule EliCD initiative</p> <p>GP referrals to EliCD initiative and links made to local GPs</p> <p>Stronger systems within Banyule CHS to ensure proactive care of clients with chronic disease</p> <p>Program is part of agency practice</p>
3.2 Develop a plan to extend the EliCD initiative across the catchment, using the experience and learnings from the Banyule EliCD initiative	<p>Year 2 Employment of an ICDM Portfolio Officer</p> <p>Establish an ICDM Working Group</p> <p>Develop a ICDM Plan for the BNPCA catchment</p> <p>Year 3 Commence implementation of ICDM plan across the catchment</p>	<p>ICDM Portfolio Officer employed to progress work as identified in this plan ICDM Working Group formed to develop an ICDM strategy for the catchment ICDM Plan for catchment commenced</p> <p>Implementation of ICDM plan across the catchment begins</p>
3.3 Address the barriers experienced by people suffering from chronic disease limiting their participation in Integrated Health Promotion initiatives	<p>Year 1 Identify the barriers of chronic disease participation in IHP initiatives</p> <p>Year 2 Address the identified barriers</p> <p>Year 3 Review participation by people with chronic disease in IHP initiatives, and make further changes if necessary</p>	<p>Comprehensive list of barriers related to chronic disease, that limit participation IHP initiatives compiled</p> <p>Solutions to barriers identified and implemented</p> <p>Feedback gained on whether barriers have been addressed</p>