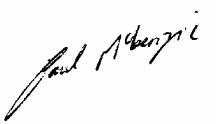
Campaspe Primary Care Partnership

Community Health Plan 2006 - 2009

Deliverable 1: Partnership

October 2006

Primary Care Partnerships
Community Health Plan

Endorsed by PCP Chair:		
Name: Paul McKenzie	Signature: 	Date: 3 November 2006

1. Partnership vision

Campaspe Primary Care Partnership's agreed vision for 2006 – 2009

Vision

'Campaspe Primary Care Partnership – Working together for healthier communities'

This vision is supported by the following mission statement as a means to achieve our vision;

Campaspe Primary Care Partnership will lead and assist members in building healthier communities through partnership, collaboration and integration. The Campaspe PCP will ensure;

- A coordinated approach to the service system
- An Integrated approach to chronic disease management
- Collaborative planning processes
- An integrated approach to Health Promotion that focuses on the social model of health to address determinants and inequalities in health, and
- Support for member organisations to improve and maintain Community participation and involvement.

Description of structure and governance

Our governance structure has been in effect since 2004. Its prime role is to provide a sustainability platform and ensure organisation ownership of our partnership. The other major goal of our governance structure is to promote leadership within member organisations. Members are the leaders of respective portfolios which ensure that the PCP supports leadership and capacity building within members.

Our governance structure also underpins our commitment to community participation and involvement with representatives at executive and operational levels.

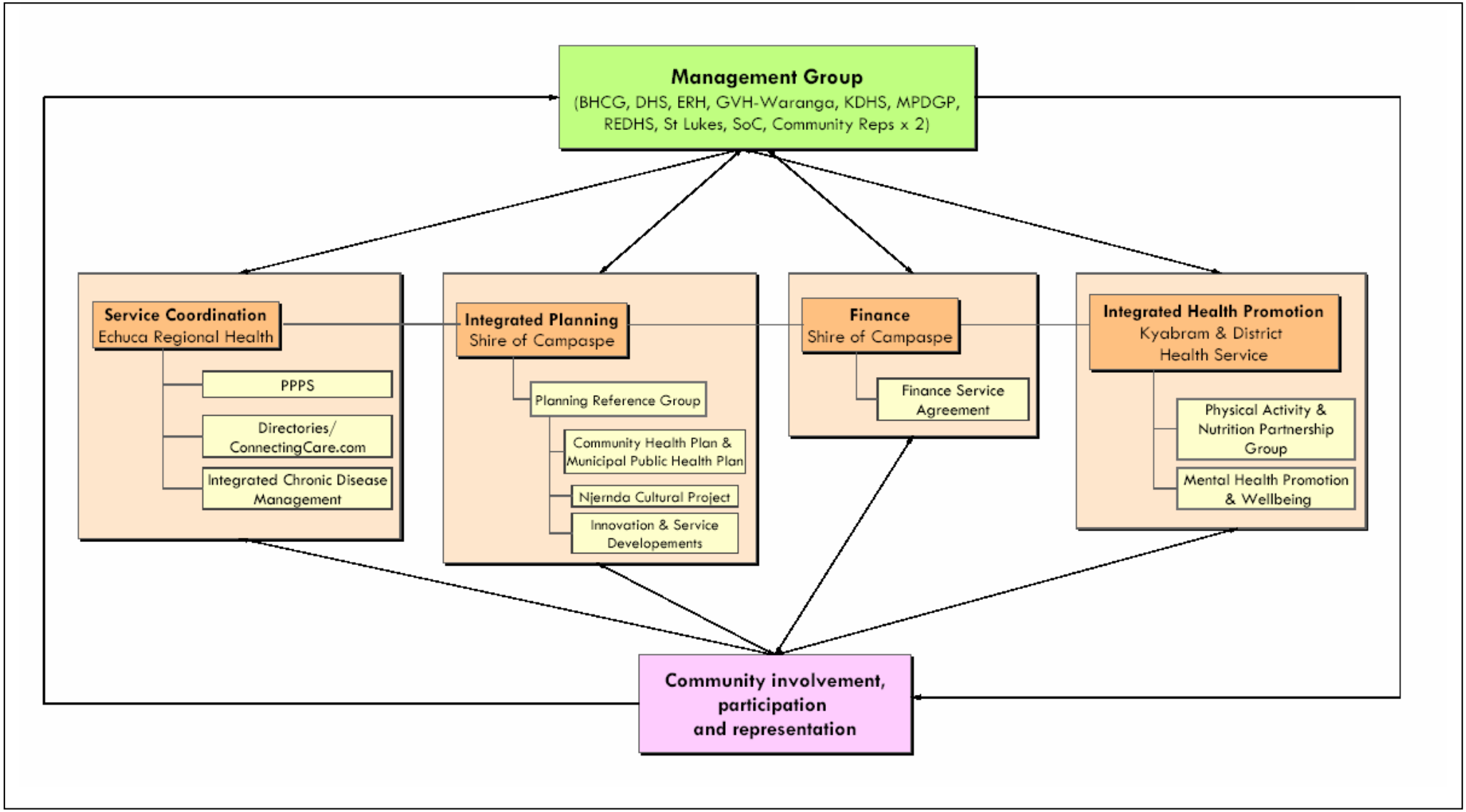


Diagram 1: Campaspe PCP Governance Structure

Our Memorandum of Understanding is undergoing another major review to support our 2006 - 2009 plans to ensure it is reflective of current goals, objectives and challenges.

Campaspe PCP has also revised our structure to maximise our memberships and guarantee quality implementation of key deliverables (refer to diagram below).

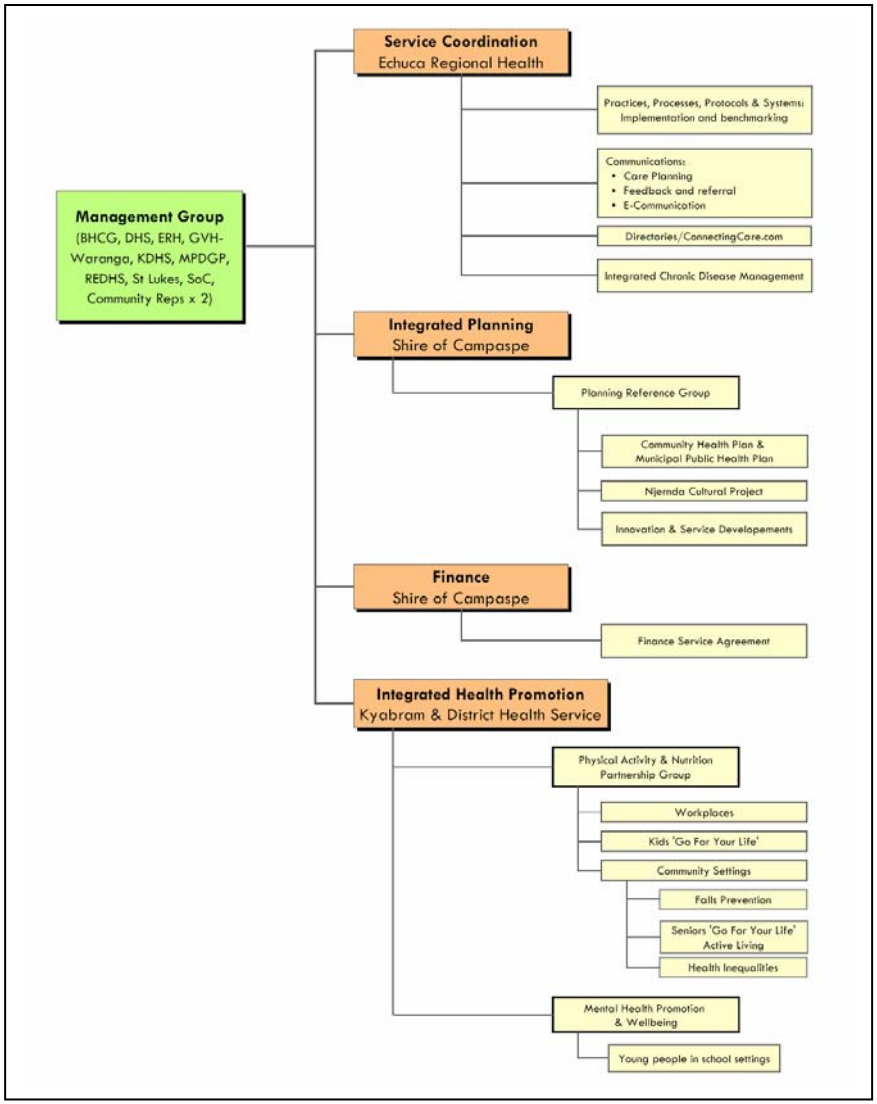


Diagram 2: Campaspe PCP Structure Chart, 2006

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

Key challenges to be addressed to achieve the vision?

Our planning workshop this year determined the need to ensure quality practices for PCP activities within full member organisations to 'lead by example'. This, in turn supports our vision in achieving members that fully embrace PCP activities who view involvement as essential for quality service provision.

Key challenges identified include;

- Working with acute and general practice
- Varying member capacities to support PCP activities
- Differing stages of partnership practices across larger member organisations.

Key Strategic Objectives & Action Areas

Leadership and Capacity Building

- Encourage and support leadership and partnering practices across all key areas
- Facilitate service system development and change management across member agencies, bringing agencies together to develop systems that support a coordinated approach

Service Coordination key areas

- Improving access for consumers through availability of service information (electronic and hard copy) - continue support/ subscription to ConnectingCare.com electronic service directory. Link with DHS Human Services Directory.
- Interface between acute services, community services and general practice
- Focus on feedback and care planning with GPs to community services and acute discharge to community services
- Electronic communication particularly between GPs, community service providers and the acute sector
- Community services and Ambulatory care interface for people with chronic conditions that require chronic disease management and care coordination
- Continued implementation of Service Coordination PPPS with strong focus on quality practice and continuous improvements by supporting existing members in improving implementation of PPPS; local benchmarking activities and statewide PPPS
- GP Support to improve communication for referral, feedback and care coordination

- Support networking for Service providers through forums and clusters
- Support for new program areas to integrate PPPS into programs

Integrated Health Promotion priority areas

- Mental Health & Wellbeing
    - Social inclusion of Young people in school environments
    - Social connectedness for drought affected communities
    - Reducing discrimination of Indigenous communities

- Physical Activity & Active Communities combined with Nutrition
    - Early years settings
    - Workplace settings
    - Community settings

Underpinning these priority areas is commitment to improve capacity to address diversity and health inequalities.

Integrated Chronic Disease Management

- Improve planning for chronic disease management
- Support change management and system integration with Service Coordination and Integrated Health Promotion
- Integrate activities with Hospital Admission Risk Program; GPs in Community Health Services; Early Intervention in Chronic Disease programs

Planning Integration and Enhancements

- Continue to utilise the Municipal Public Health Plan as the key strategic planning document for Campaspe
- Increase service data and evidence data collection
- Integrate organisational level priority setting and planning
- Foster and enhance partnerships to achieve a higher level of planning integration
- Continue to support place based and community based planning approaches

Mental Health

- Support for drought affected communities
- Effective Follow Up of Suicidal Patients in Hospital Emergency Departments Project continued support for workforce development and consumer access to services

- Support recommendations from the Loddon Campaspe Southern Mallee Community Mental Health Plan and integrate with their planning processes
- Engage with the Divisions of General Practice Better Outcomes for Mental Health program

Support for Aboriginal Communities within Campaspe

- Continue to work with Njernda Aboriginal Corporation to advance developments based on the community consultation completed in November 2005
- Kyabram Aboriginal Community support as requested by the community

Supporting Innovation and Service Developments

- Continue commitment to supporting innovation
- Foster potential developments that enhance our service system and gain better outcomes for our communities through
    - funding opportunities, and
    - partnerships with other departments and sectors
    - priority areas include General Practice; Early Childhood; Mental Health and communities experiencing inequalities

Regional Opportunities

Active membership in the Loddon Mallee Region PCP Network and Loddon Mallee PCP Chairs Network to support

- sharing of resources,
- regional representation
- continued collaboration on relevant projects/tasks, and
- additional regional opportunities.

3. Achieving the vision: *Capacity Building Plan*

Partnerships

Goal	Objective	Strategies/Interventions	Estimated Impact
To support and enhance our current partnerships	Review and monitor partnership strengths and deficits	Apply VicHealth Partnership Analysis tool annually - develop action plan to address deficits	Increased participation from members in PCP activities Continuous improvement strategies in place Effective governance practices applied 100% of members actively involved in PCP activities
		Undertake Memorandum of Understanding review in line with Community Health Plan for 2006 – 2009	
		Revise full MoU member Service Agreements for 2006 – 2009 period	
	Increase engagement, active participation and implementation within member organisations	Support Affiliate member participation in Steering committees, working groups and local forums	
		Conduct annual reviews of key portfolio and key action areas structures and terms of reference	
	Improve support for PCP by member organisation senior managers and boards of management	Conduct senior manager and board forums	
To encourage new partnerships or recognition of partnerships not already supported with PCP membership	Work with cross sector agencies to support social determinants and health inequalities approaches	Support and engage partners including Crossenvale Project and private practitioners	Partners involved in PCP activities

	Strengthen links with General Practitioners	Continue to support MPDGP participation in PCP activities - Refer to Service Coordination Plan; Integrated Chronic Disease Plan and Integrated health Promotion Plan	
To support community participation and involvement	Continue to support and enhance consumer participation within PCP member agencies and activities	Ensure community representative participation in working groups where possible	Community Representatives involved in PCP Management Group and working groups
		Recruit Management Group Community representative positions through member organisations	
		Support member organisation community participation strategies where relevant	

Leadership

Goal	Objective	Strategies/Interventions	Estimated Impact
Support leadership through member organisations	Key portfolios to be lead by agreed organisations	Tasks/responsibilities included in Portfolio position descriptions adopted into member agency individual and team workplans	Increased organisational leadership from members Increased participation in lead roles from members
	Key projects/initiatives to be lead by member organisation	All PCP projects to recruit project staff from member organisations through Expression of Interest and selection process	
	Steering Committees and working groups to be lead by member organisations	Enable a team approach to PCP activities	

	Encourage and support leaders within each organisation for each of the key deliverable areas	Member agencies to ensure participation in each of the key areas by minimum of one staff member	Increased leadership – minimum of one leader/member organisation staff who has a leadership role for their organisation in IHP, SC and ICDM

Organisational Development

Goal	Objective	Strategies/Interventions	Estimated Impacts
PCP members fully commit to PCP strategy	PCP member organisations apply partnership practice as agreed through the Memorandum of Understanding	Relevant areas from the CHP are implemented by member organisations	Responsibility for achieving PCP goals shared amongst PCP members Member organisations strategic plans reflect PCP commitment and involvement Member organisations work/operational plans reflect PCP activities
		Member organisations ensure they are participating in PCP activities	
	PCP full MoU member organisations implement 2006 - 2009 Service Agreement	Partnering MoU member responsibilities as detailed in Service agreements to be adopted into member agency individual and team workplans	
		Members include PCP activities in own organisational strategic and operational planning	
To support member participation in decision making	To ensure shared and transparent decision making processes are applied to all PCP strategies	Conduct priority setting processes as per agreed Priority Setting Protocol	Clear, transparent processes applied to 100% of PCP decision making
		Strategic Planning involves all key members	
		MoU is endorsed through Management Group decision making processes	

Workforce Development

Goal	Objective	Strategies/Interventions	Estimated Impact
Increase member organisations knowledge and skills in partnership practices and activities	Support and encourage skill development in effective partnerships	Professional development is supported for each key portfolio area	Increased workforce skills and knowledge in partnerships
		Staff development activities are supported by PCP portfolios and activities	Increased workforce skills and knowledge in key PCP portfolio areas
		Supportive mentoring and supervision structures supported by all PCP activities and projects	
		PCP actively provides and seeks opportunities for professional development	

Resources

Goal	Objective	Strategies/Interventions	Estimated Impact
To implement the vision and mission of Campaspe PCP	Provide executive support functions to the Campaspe PCP Management Group	Support Chair person leadership	Key objectives of PCP are implemented
		Implement the Community Health Plan Partnership plan and key strategic objectives	
		Support and coordinate implementation of the Integrated Health Promotion plan; Service Coordination plan and Integrated Chronic Disease plan	
	Facilitate and coordinate systems integration and change management across member organisations	Support portfolio structure and leadership roles of members	Members support PCP activities though involvement
		Support participation and involvement of members in PCP activities and key areas	

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

All organisations providing health and primary care services in the Campaspe area are eligible for Campaspe Primary Care Partnership membership.

Membership is supported through two levels within the Campaspe Primary Care Partnership and are classified as;

- Memorandum of Understanding members, and '
- Affiliate members.

A Memorandum of Understanding member organisation is a member that demonstrates commitment to the strategic objectives of the partnership and actively contributes to activities across the key portfolio areas of Service Coordination and Integrated Health Promotion. A MoU member also has signed commitment and agreement to the Rights and Responsibilities statement for MoU organisations. All primary care funded agencies that have the resource capacity, are expected to be involved as members of Campaspe PCP.

An Affiliate member organisation is one who is committed to the strategic objectives of the partnership, but may not have full resource capacity to participate in all key areas and therefore contributes in an advisory capacity.

Campaspe PCP has eight MoU member organisations including local government, divisions of general practice, community health, allied health, hospitals, mental health, aged care and welfare. In addition to member organisations, Campaspe PCP has two Community representative positions that have the same voting rights as MoU members share.

A further 15 organisations are Affiliate members ranging from aboriginal community controlled organisation, sport and recreation, housing, disability, women's health, adult education, NSW health and community services, and service specific organisations.

Agency name	Type of membership	Deliverable/s involved in
Bendigo Health Care Group	Full Memorandum of Understanding member	Partnership executive; Service Coordination & Integrated Health Promotion Administers electronic service directory

Agency name	Type of membership	Deliverable/s involved in
Echuca Regional Health	Full Memorandum of Understanding member	Partnership executive; Service Coordination & Integrated Health Promotion Service Coordination Portfolio holder
Goulburn Valley Health – Waranga (including Waranga Aged Care)	Full Memorandum of Understanding member	Partnership executive; Service Coordination & Integrated Health Promotion
Kyabram and District Health Services	Full Memorandum of Understanding member	Partnership executive; Service Coordination & Integrated Health Promotion Integrated Health Promotion Portfolio holder
Murray Plains Division of General Practice	Full Memorandum of Understanding member	Partnership executive; Service Coordination & Integrated Health Promotion
Rochester and Elmore District Health Service	Full Memorandum of Understanding member	Partnership executive; Service Coordination & Integrated Health Promotion
Shire of Campaspe	Full Memorandum of Understanding member	Partnership executive; Service Coordination & Integrated Health Promotion Planning Portfolio holder Finance Portfolio holder Lead Agency
St Lukes Anglicare	Full Memorandum of Understanding member	Partnership executive; Service Coordination & Integrated Health Promotion
Community Representatives	Voting members	Partnership executive
Bendigo Regional BreastScreen	Affiliate member	Partnership; information sharing and networking
Centre Against Sexual Assault – Loddon Campaspe region	Affiliate member	Partnership; Service Coordination
Community Living and Respite Services	Affiliate member	Partnership; Service Coordination; Information

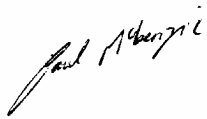
Agency name	Type of membership	Deliverable/s involved in
		Sharing and Networking
Greater Southern Area Health Service (NSW)	Affiliate member	Partnership; Integrated Health Promotion
Interchange	Affiliate member	Partnership; Integrated Health Promotion
Kyabram Community and Learning Centre	Affiliate member	Partnership; Integrated Health Promotion
Lockington Bush Nursing Centre	Affiliate member	Partnership; Service Coordination
Loddon Mallee Housing	Affiliate member	Partnership; information sharing and networking
Murray Human Services	Affiliate member	Partnership; Service Coordination
Murray Shire Council (NSW)	Affiliate member	Partnership; Information Sharing and Networking
Njernda Aboriginal Corporation	Affiliate member	Partnership; Integrated Health Promotion
Sports Focus	Affiliate member	Partnership; Integrated Health Promotion
Women's Health Loddon Mallee	Affiliate member	Partnership; Integrated Health Promotion
YMCA – Greater Murray	Affiliate member	Partnership; Integrated Health Promotion

Deliverable 2: Integrated Health Promotion

October 2006

Campaspe Primary Care Partnership

Community Health Plan

Endorsed by PCP Chair:		
Name: Paul McKenzie	Signature: 	Date: 3 November 2006

1. IHP vision

State the vision for IHP in your PCP.

The longstanding vision for Integrated Health Promotion in Campaspe is 'that health promotion practices within the Shire of Campaspe are responsive to the health and well-being needs of the community'. The Campaspe PCP Health Promotion Steering Committee goal has been 'to provide opportunities to integrate and coordinate a range of health promotion activities in an environment which is supportive of continuous improvement and community involvement.' Key objectives to achieve this vision have been to

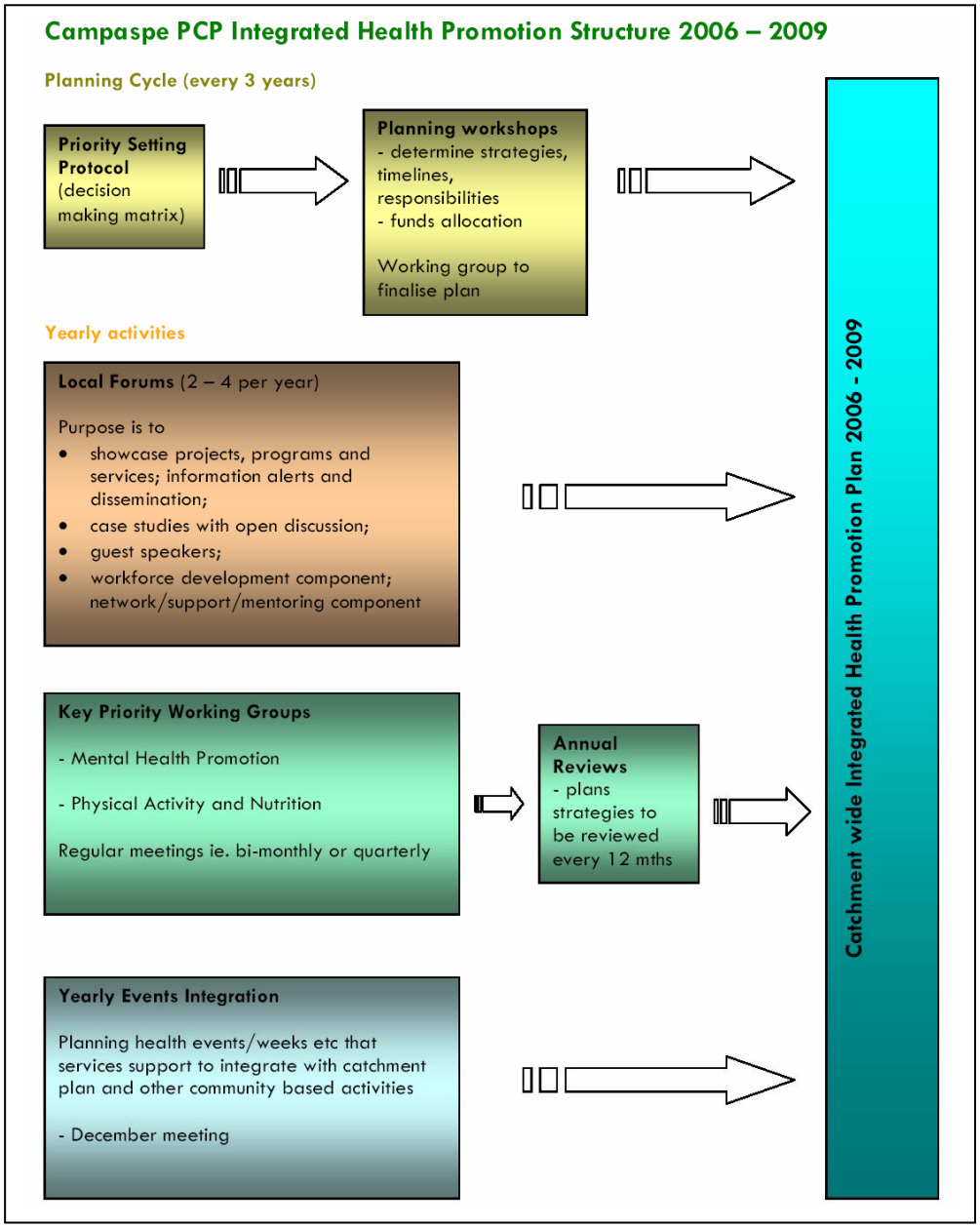
- To promote a collaborative approach between key health promotion agencies
- To continue to engage with agencies that have an interest in improving health and well being
- To foster and strengthen integrated health promotion approaches
- To act as a reference committee for health promotion agencies and consumers
- To involve consumers in all phases of health promotion development
- To influence policy development and resource allocation to improve health promotion outcomes within the Campaspe Shire
- To base health promotion activities on evidence-based practices
- To support the process, impact and outcome evaluation guide in achieving quality health promotion practice for Campaspe.
- To encourage resource sharing of good practice health promotion projects.

These goals and objectives form the foundation for our work progressing into 2006 – 2009; however, a change in structure will be implemented for 2006 - 2009 for Campaspe PCPs IHP portfolio, which is supported by the development of an IHP Partnering Agreement between our local Community Health services. The key goal of this Partnering Agreement is 'to work together collaboratively to consolidate the health promotion effort and improve the quality of integrated approaches to health promotion planning, implementation, evaluation and dissemination in the Campaspe catchment'. The Partnering Agreement allows the PCP to have a greater strategic focus and supports the shift to focus on capacity building. This effectively demonstrates the advancement of our partnership to indicate true sharing of responsibility and uptake of PCP initiatives into organisations core business.

Campaspe PCPs IHP vision for 2006 – 2009 is to 'improve the health of the Campaspe population, by improving the delivery of IHP approaches through application of evidence based and best practices'.

It is expected that this will achieve a consolidated and focused effort not only for our target priorities, but also for any additional health promotion efforts to support use of resources more effectively and efficiently.

The 2006 - 2009 structure is visually presented in the diagram below;



The key objectives for the new Campaspe PCP IHP structure are to;

- Maintain effective partnership approaches by supporting development of teams and working groups
- Share the responsibilities of health promotion by using local networks and partnerships strategically to support IHP approaches
- Communicate in a range of contexts
- Share local learning's and provide reflective practice opportunities
- Support mentoring and leadership for IHP
- Continue to increase skills and knowledge in IHP
- Improve staff abilities to advocate for HP practice and principles in organisational planning and system developments

Campaspe PCP and the IHP Portfolio has a leadership role in

- supporting catchment planning
- encouraging a catchment wide effort to reduce duplication and fragmentation of effort/ consistency for a population health approach
- strengthening the capacity of the service system to plan, implement and evaluate IHP programs, and
- reorienting services to be population focused.

2. Priority setting and problem definition

The process for selecting IHP catchment priorities

Campaspe PCP has a thorough process to effectively set the catchment wide health promotion priorities applied through our Priority Setting Protocol. This process is comprehensive, consultative and transparent to ensure decisions are based on identified need. This process was initially applied for the 2004 – 2006 planning period. This year, reflective enhancements were made to the weighted decision criteria primarily in the evidence section to include community consultation data due to the level of consultation information available. Each of the criteria is listed below with key consideration items as follows;

Evidence:

- Ambulatory Care Sensitive Conditions study data
- Burden of Disease data
- Hospital admissions data
- Organisational plans and the Municipal Public Health Plan including other council plans such as the Municipal Early Years Plan, Recreation plan etc.
- Community Consultation data including consultation for the MPHP and information gained from the PCP 2006 Consumer Forum
- Service provider consultation through the MPHP process

Capacity Building:

- Service system gaps – lack of resources
- Recommendations from working groups, steering committees or executive
- Opportunities for intersectoral collaboration
- Staffing capacity to undertake action

Strategic:

- Opportunity to link to other funding sources
- Links to DHS strategic directions
- Link to national, state and regional priorities
- Links to local agency plans

This process was completed for the key statewide priority areas as well as any additional local priorities that present outside of the key statewide areas. The matrix conclusions resulted in strong indicators in the following order;

1. Physically active communities
2. Mental health and wellbeing
3. Nutrition
4. Tobacco, alcohol and other drugs
5. Injury prevention

Step two of our Priority Setting Protocol advanced discussions regarding each of the key areas in relation to their urgency for action and potential to achieve IHP/strategic impact. It was found that the following priorities had an equal 'urgency for action' combined with greatest impact potential;

- **Physically active communities,**
- **Nutrition,** and
- **Mental health and wellbeing.**

Another major consideration at this point was for current capacity of our workforce in terms of resources available to contribute to the key areas. Further to this conclusion, agreement was made that if additional resources became available to support implementation of IHP, additional priority areas could be actioned in a catchment wide approach.

Problem Definition/ Rationale

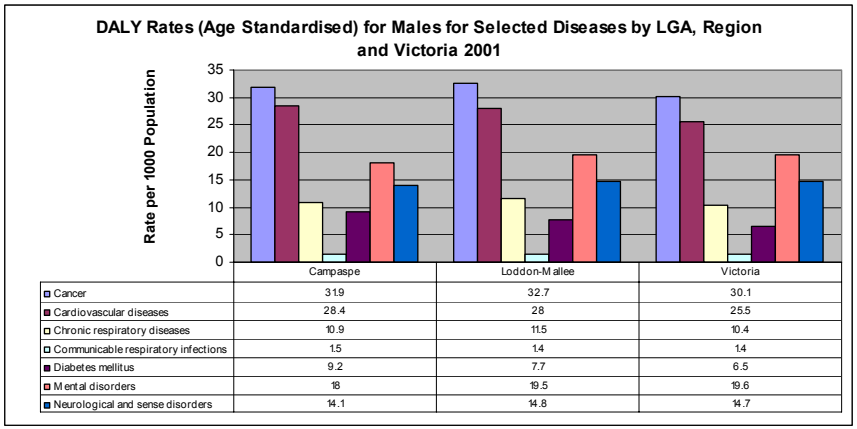
Physically Active Communities and Nutrition

Campaspe PCPs key priority area for 2004 – 2006 was physical activity. During this time it was found that for a number of the strategies implemented it was essential to include nutrition, therefore, we have combined these key priorities to support these approaches for 2006 – 2009. This is particularly relevant for key action areas such as 'Go for your life' and falls prevention activities.

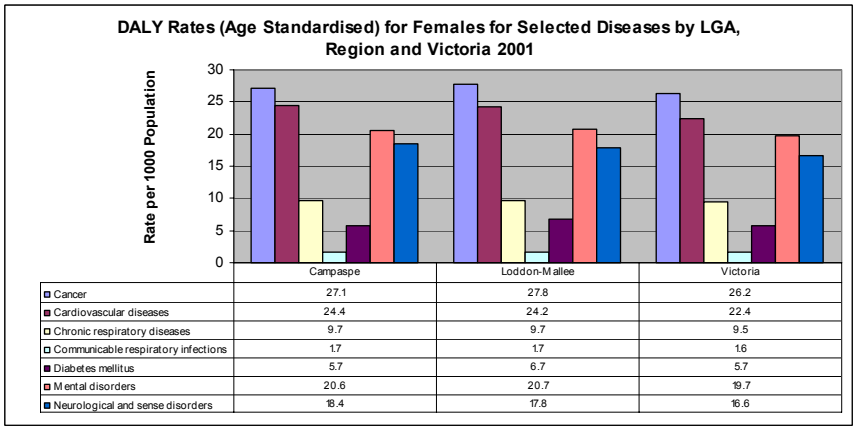
Further to this, our progress in our physical activity work from 2004 – 2006 has been more than anticipated in some areas but delayed in others; therefore it was strongly recommended that we continue physical activity as a priority area by the Campaspe PCP IHP portfolio and build on the assets and strengths created to date.

The basis for these priorities is similar to that from our previous rationale from 2004 –2006. The need to focus on physical activity and nutrition relates to;

- the high incidence of angina, asthma, COPD and diabetes complications from the Ambulatory Care Sensitive Conditions Study;
- the top two major disease burdens are cancers and cardiovascular disease from the Burden of Disease data (see tables below);



	Campaspe	Loddon-Mallee	Victoria
Cancer	31.9	32.7	30.1
Cardiovascular diseases	28.4	28	25.5
Chronic respiratory diseases	10.9	11.5	10.4
Communicable respiratory infections	1.5	1.4	1.4
Diabetes mellitus	9.2	7.7	6.5
Mental disorders	18	19.5	19.6
Neurological and sense disorders	14.1	14.8	14.7



	Campaspe	Loddon-Mallee	Victoria
Cancer	27.1	27.8	26.2
Cardiovascular diseases	24.4	24.2	22.4
Chronic respiratory diseases	9.7	9.7	9.5
Communicable respiratory infections	1.7	1.7	1.6
Diabetes mellitus	5.7	6.7	5.7
Mental disorders	20.6	20.7	19.7
Neurological and sense disorders	18.4	17.8	16.6

- physical inactivity; obesity and high blood pressure also referenced by the Burden of Disease Study;
- strong community identified need;
- strong potential for intersectoral collaboration by working with other service sectors; and
- the ability to integrate priorities and programs

Goal for Physical Activity and Nutrition

To increase participation in physical activity and improve access to nutritious food.

Mental Health and Wellbeing

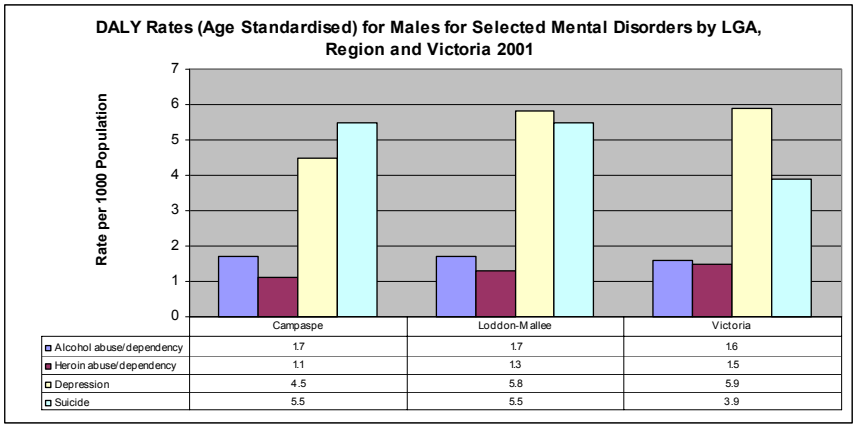
Mental Wellbeing and Social Connectedness was integrated into Campaspe PCPs IHP plan for physical activity for 2004 – 2006. This was based on reviews that recognised the mental health benefits of physical activity and evidence from trials that indicated physical activity outcomes in reducing the symptoms of depression and as effective as meditation or relaxation in the treatment of anxiety[1].

The rationale context for Campaspe's focus on mental health and wellbeing relate to;

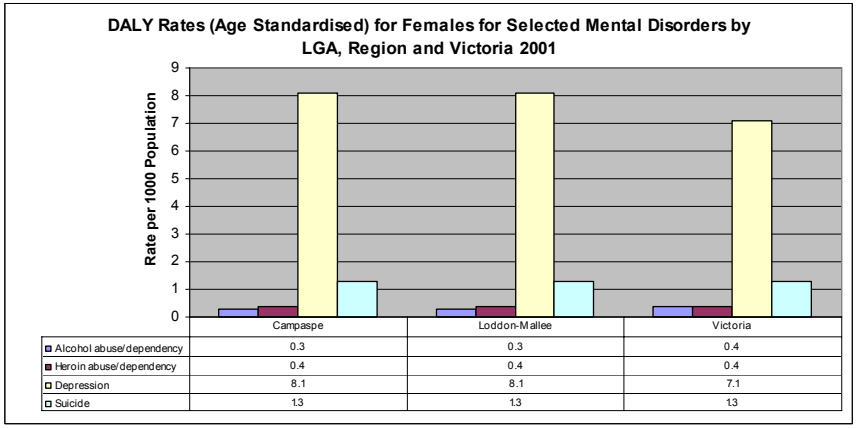
- mental disorders being the third leading Burden of Disease for Campaspe for both males and females

[1] Campaspe Primary Care Partnership (September 2004) Community Health Plan 2004 – 2006

- increasing incidence and rates of depression and suicide from 1996 to 2001 Burden of Disease data (see tables below);



	Campaspe	Loddon-Mallee	Victoria
Alcohol abuse/dependency	1.7	1.7	1.6
Heroin abuse/dependency	1.1	1.3	1.5
Depression	4.5	5.8	5.9
Suicide	5.5	5.5	3.9



	Campaspe	Loddon-Mallee	Victoria
Alcohol abuse/dependency	0.3	0.3	0.4
Heroin abuse/dependency	0.4	0.4	0.4
Depression	8.1	8.1	7.1
Suicide	1.3	1.3	1.3

- Campaspe's suicide rate for both males and females is the same as that across the Loddon Mallee region. These rates however have increased from the 1996 period by approximately 25%. Incidents are most frequently being experienced by females between the ages of 15 – 54 years (42 incidences) and by males between the ages of 15 – 44 years (30 incidences). Campaspe's rates are above the state average for males however our female rates are consistent with the state average. Anecdotal evidence suggests that the impact of the drought is a major contributor to these increased rates for our region.
- Depression rates have also risen during the 1996 – 2001 period. The increase in depression is being experienced by Victoria as a whole however Campaspe's rate for females is slightly above average and slightly below for males.
- identified need from the service system experiencing large demands on counselling and mental health services
- strong community identified need, and
- the Loddon Campaspe Southern Mallee Community Mental Health Plan consultation in October 2005 highlighted need for MHP to be coordinated, integrated and have all stakeholders involved
    - Need to increase our skills and knowledge in MHP
    - MHP needs structural support as it's 'nobody's core business' and is beyond the capacity of existing workers
    - Needs a concentrated effort, resources and priority setting for groups to do well

Goal for Mental Health and Wellbeing

To increase mental wellbeing and social connectedness

3. Solution generation

Mix of interventions

The information in this section will be provided using Option 1.

Physical Activity and Nutrition

A key stakeholder planning session was held to develop the goal, objectives and relevant evidence based strategies for these key priority areas. The purpose of this forum was to ensure participants;

- Be aware of the evidence based approaches and strategies
- Have contributed to defining population groups to target
- Have contributed to the development of clear program objectives
- Have had the opportunity to discuss potential strategies for implementation during 2006 - 2009.
- Have developed appropriate evaluation measures

This forum was supported by a lecturer and Research Fellow with Deakin University's Centre for Physical Activity and Nutrition. The Deakin representatives assisted in the planning of the forum and presented research finding summaries on the day. These findings assisted the determination of the population groups of the IHP catchment plan focus for the next three years and appropriate evidence based strategies.

Further to this workshop, a combination of interventions have been adopted for this plan based on;

- a literature review conducted in 2004 (as per Campaspe PCP Community Health Plan 2004 – 2006)
- 'Planning for healthy communities - Reducing the risk of cardiovascular disease and type 2 diabetes through healthier environments and lifestyles' (DHS, 2004) Evidence based review document
- Review and evaluation of Campaspe PCP Physical Activity plan 2004 – 2006
- arising evidence and research (as presented at the forum)
- existing work plans, particularly for the Falls Prevention Project, Seniors 'Go for your life'/ Campaspe Healthy and Active Living for Seniors project, and Kids 'Go for your life' initiatives, and
- the collective work completed at the strategies workshop by major stakeholders.

Findings have informed the strategies as outlined in the following Summary Planning Grids.

For 2006 – 2009 the IHP partnership group has been extended to continue to work with early years, workplaces and older adults population groups as well as including people experiencing disadvantage and inequalities in communities throughout Campaspe. This focus will be directed at those in rurally isolated areas, the Crossenvale neighbourhood in Echuca, those experiencing chronic disease and other groups experiencing low socio-economic status. Campaspe PCPs IHP planning process has focussed strongly on inequalities and objectives have been selected to address determinants of health – all member organisations supporting the PCP IHP plan are committed to addressing inequalities.

Program objectives have been designed to be achievable and directed at changing or creating an environment supportive of change for personal, social and organisational factors that meet community's needs.

Further detail of intervention Implementation plans can be sources from Partner Organisation Plans, notably;

- Echuca Regional Health – Health Promotion Organisation Plan
- Kyabram & District Health Services - Health Promotion Organisation Plan
- Shire of Campaspe – Kids Go for your life plan

Integrated Health Promotion Catchment Implementation Plan 2006–09

Key action area 1 – Early Years Settings

Priority Goal:	**To increase participation in physical activity and improve access to nutritious food** To promote healthy nutrition and active play in the early years
Objective (s):	To decrease consumption of energy dense foods Increase fruit and vegetable consumption Increase water consumption Reduce sedentary behaviours Encourage active play Promote Authoritative Parenting
Est. Impacts (Qual/ Quant)	Increased knowledge by Parents/Families about healthy eating and physical activity Parents/families/teachers report changes in behaviours to support KGFYL messages 100% Community health services are in partnership with local government to implement KGFYL Early Years staff report increased knowledge in healthy eating and physical activity 50% of Early Childhood services accredited with KGFYL membership 50% of Primary Schools accredited with KGFYL membership

Summary of mix of Interventions	Key implementation partners	Population Target Group/s:	Estimated timelines (Optional)	Estimated Reach	Estimated intervention resources per member
Social marketing and Health information Develop communications strategy to address community perceptions; promote KGFYL messages and active transport Provide media releases for local newspapers and centre newsletters Utilise fundraisers, open days, fetes etc to promote KGFYL messages	Local government Community Health Primary Schools Early childhood centres Campaspe Early Childhood Network Primary Schools Clusters	General community Parents Children		2,000	KDHS: Physiotherapist 0.05 EFT Dietician 0.4 EFT REDHS: 0.1 EFT b/w CHN, HPO ERH: CHN 0.1 EFT, Parenting SoC: Family Services – KGFYL, MCH, Childcare KGFYL Coordinator for 06/07
Health education and skill development Provide education to parents, care providers and children on; - encouraging active play/reducing screen watching time - active play options/ activity breaks etc - Promote Authoritative parenting Implement Smiles for Miles, Start Right Eat Right programs for early childhood services Implement Fruit + Veg programs Implement TravelSmart (if successful with funding application)		Parents Children			
Community action Support parent groups to encourage and assist with providing positive environment Engage 'champion' councillors Support and encourage parents to join working groups to support implementation		Parents			

Settings and Supportive Environments Conduct needs analysis (surveys, focus groups, interviews) Influence policy change/development – environmental and culture Support access to active play/increase opportunities Influence canteen/ provision of healthy food Replace sweetened drinks with water; provide access to clean safe water Engage economic development to work with food retailers Engage Canteen Advisory Service to assist canteen policy and planning Promote local walking tracks, sporting facilities, playgrounds, parks etc		Primary Schools Early Childhood settings		10 - 15 Primary schools 5 early childhood settings	
Estimated Total Budget per Objective : Refer to Organisational Plans					
Estimated Total Budget per Goal :					

Key action area 2 – Workplace Settings

Priority Goal:	**To increase participation in physical activity and improve access to nutritious food** To promote health and wellbeing of residents in the Shire of Campaspe using the workplace setting				
Objective (s):	To determine 'at risk' /low SES workers and workplaces of poor health outcomes in the Shire of Campaspe by March 2007 To implement healthy lifestyle changes in at risk workplaces Create supportive environment in 3 workplace settings (adopt healthy environments and practices for employees)				
Est. Impacts (Qual/ Quant)	Refer to Organisational Plans				
Summary of mix of Interventions	**Key implementation partners**	**Population Target Group/s:**	**Estimated timelines (Optional)**	***Estimated* Reach**	**Estimated intervention resources per member**
Health education and skill development Provide education on healthy lifestyle practices - group and setting based - GP based 'Lifescripts' -	Community Health Division of General Practice			400 employees	KDHS: Physiotherapist 0.1 EFT Dietician 0.05 EFT HPO 0.1 EFT REDHS: 0.1 EFT CHN/HPO
Community action Support and encourage advocacy to accessible affordable nutritious food	Local government Community Health				

Settings and Supportive Environments Investigate Campaspe demographics and health outcomes determinants related to low SES population groups. Look at workplace settings that have 'at risk'/low SES employees (eg. supermarkets, factories, abattoirs, other disadvantaged) Prepare evidence research into health outcomes of employees Follow Workplace Engage management – develop EOI criteria to be involved Conduct workplace needs analysis (surveys, focus groups, interviews) - determine current practices and risks - determine accessibility to facilities; information; - determine knowledge and skills - determine participation in sport and recreation Influence policy change – environmental and culture Support access to physical activities/increase opportunities; organise team activities Influence canteen provision of healthy food	Community Health and partners (see right column)			3 workplaces	ERH: HPO 0.2 EFT SoC: Recreation, Community Development, Environmental Health & Immunisation MPDGP, Sports Focus, YMCA, Local sporting groups and facilities
Estimated Total Budget per Objective : Refer to Organisational Plans					
Estimated Total Budget per Goal :					

Key action area 3 – Community Settings

Priority Goal:	**To increase participation in physical activity and improve access to nutritious food** To improve physical activity and nutrition in community settings				
Objective 1:	Increase options and access to **physical activities for people with a disability and the aged** by June 2009 (30 mins per day 5 times per week)				
Est. Impacts (Qual/ Quant)	Increased participation in physical activity Increased participation in variety of physical activities				
Summary of mix of Interventions	**Key implementation partners**	**Population Target Group/s:**	**Estimated timelines (Optional)**	***Estimated* Reach**	**Estimated intervention resources per member**
Screening, individual risk assessment and immunisation Work with MPDGP to investigate the Lifescript program and application with target group	Murray Plains Division of General Practice				
Health education and skill development Provision of a range of activity programs for older adults - strength and balance exercise programs - chair based exercises - home based programs - community gardens and - mens shed programs	Community Health Neighbourhood houses Healthy and Activity Living Coordinator	Isolated older adults; low SES, people with chronic diseases; people with disabilities		200 - 300	KDHS CHN 0.5 EFT Physiotherapist 0.05 EFT YMCA Rural Health Team
Settings and Supportive Environments Support sport and recreation providers to adopt inclusive principles and actively seek participation from Aged and Disabled through; - creation of peer participation opportunities - Newcomer's days/Open days - Come and Try events etc Support community leaders development	Community Health Rural Access Sports Focus Healthy and Activity Living Coordinator				ERH HPO 0.1 EFT REDHS
Estimated Total Budget per Objective: Refer to Organisational Plans					
Estimated Total Budget per Goal :					

Priority Goal:	**To increase participation in physical activity and improve access to nutritious food** To improve physical activity and nutrition in community settings
Objective 2:	By June 2009, increase **knowledge of and access to affordable nutritious food for disadvantaged people** and the unemployed (5 vegetables and 2 fruit)

Est. Impacts (Qual/ Quant)	Increased knowledge of nutrition education Increase accessibility and availability of nutritious food				
Summary of mix of Interventions[2]	**Key implementation partners**	**Population Target Group/s:**	**Estimated timelines (Optional)**	**Estimated Reach**	**Estimated intervention resources per member**
Screening, individual risk assessment and immunisation Work with MPDGP to investigate the Lifescript program and application with target group		Unemployed Low SES; people with chronic diseases; people with disabilities			KDHS: Dietician 0.05 EFT REDHS: CHN SoC: Rural Access, Recreation, Community Development, Falls Prevention MPDGP, Sports Focus, YMCA, CLRS
Social marketing and Health information Provide information and literature, GFYL marketing resources	Community Health				
Health education and skill development Provide nutritional education to target group	Community Health				
Community action Encourage advocacy for access to affordable nutritious food	Local government Community health				
Settings and Supportive Environments Investigate barriers for target group to access nutritious food Support the development of community access points to nutritional foods by developing a pilot approach for Community gardens or Farmer's Markets that encourage access for disadvantaged Support community access points to provide nutritional meals - STEPS - Neighbourhood houses etc Investigate other funding opportunities to gain additional support for the advancement of this area.	Community Health Neighbourhood houses		November 2006 – March 2007		
Estimated Total Budget per Objective : Refer to Organisational Plans					
Estimated Total Budget per Goal :					

Mental Health and Wellbeing

A key stakeholder planning session was also held for mental health promotion to develop the goal, objectives and relevant evidence based strategies for these key priority areas. This forum was facilitated by a Health Promotion Consultant skilled and knowledgeable in the VicHealth Mental Health Promotion Short Course. The purpose of this forum was for participants to;

- Have contributed to defining population groups to target
- Have contributed to the development of program objectives for the priority of mental health promotion
- Have had the opportunity to discuss potential strategies for implementation during 2006 - 2009.
- Have had the opportunity to discuss and define expected outcomes and success criteria
- Be aware of the evidence based approaches and strategies that prevent mental health

Working groups continued the planning action required arising from the workshop. This work assisted the determination of the population groups that the IHP catchment plan will focus on over the next three years and appropriate evidence based strategies.

Further to this workshop, a combination of interventions have been adopted for this plan based on;

- 'Evidence-based Mental Health Promotion Resource' (DHS, 2006) Evidence based review document
- VicHealth 2005 Framework for the Promotion of Mental Health and Wellbeing
- arising evidence and research (as presented at the forum)
- 'Summary of effective strategies to address bullying in schools' (Campaspe PCP, 2006)
- existing work plans, particularly for schools MindMatters programs and Youth Focussed School Services, and
- the collective work completed at the strategies workshop by major stakeholders.

From these processes, three key population groups identified for IHP action for 2006 – 2009 are young people, Indigenous people and communities affected by drought.

The interventions and strategies selected are summarised below in both the Summary Planning Grid and narratives.

Program objectives have been designed to be achievable and directed at changing or creating an environment supportive of change for personal, social and organisational factors that meet community's needs.

Further detail of intervention Implementation plans can be sources from Partner Organisation Plans, notably;

- Echuca Regional Health – Health Promotion Organisation Plan
- Kyabram & District Health Services - Health Promotion Organisation Plan
- Shire of Campaspe – Youth Services plan

Integrated Health Promotion Catchment Implementation Plan 2006–09

Key action area 1 - Social Inclusion for Young people

Priority Goal:	**To improve mental wellbeing and social connectedness** To increase social inclusion of young people aged between 12 – 19 years				
Objectives:	To reduce the impact of bulling on young people within school settings To implement best practice - whole of school approach to bulling in 4 schools in Campaspe by the end of June 2009				
Est. Impacts (Qual/ Quant)	Refer to Organisational Plans				
Summary of mix of Interventions	**Key implementation partners**	**Population Target Group/s:**	**Estimated timelines (Optional)**	***Estimated* Reach**	**Estimated intervention resources per member**
Social marketing and Health information Press releases though local media and school newsletters to raise awareness of types of bullying, bullying impacts, and project activities	Community Health, Schools/Education	General and school community		3,000	ERH: HPO 0.1 EFT KDHS: CHN 0.05 EFT REDHS: 0.1 EFT CHN/SW SoC: YPO 0.2 EFT
Health education and skill development Implement school based leadership, assertiveness, peer partnering and resilience programs for students	Schools/Education Community Health	Young people Parents		1,000	
Community action Support and promote Youth participation activities - Youth Council - Youth FReeZA committees - Community Planning Groups - Youth Action Groups	Local government Schools	Young people			
Settings and Supportive Environments Develop framework based on research on best practice models School policy and procedures - development of comprehensive protocols to respond to bullying and supportive of prevention of bullying	Schools – senior management, teachers, parents and students Community Health	Young people Teachers			
Organisational Development Expression of Interest process to be developed inviting schools to submit to be involved in program. Selection to be based on criteria Ensure school support is provided to the project	Schools Community Health	Schools	November – December 2006	4 schools	
Estimated Total Budget per Objective : Refer to Organisational Plans					
Estimated Total Budget per Goal : Refer to Organisational Plans					

Key action area 2 – Social Connectedness for Drought affected communities

Summary/outline of the mix of interventions:

Interventions targeting drought affected communities are aimed to address social connectedness and mental wellbeing, particularly suicide prevention. These strategies are based on the actions of the Campaspe Drought Recovery Committee and Campaspe Murray Mental Health Network. As of October 2006, these strategies are not confirmed by all key stakeholders due to unknown resource allocation from state government to support efforts. However, regardless of funding provided, Campaspe PCP organisations will endeavour to meet as many of the strategies as possible.

Screening, individual risk assessment and immunisation Encourage GPs to undertake risk screening for all drought affected clients
Social marketing and Health information Promote messages to community on the need for support and to 'take care of your neighbours'
Health education and skill development Provide training to key community members and general communities in Mental Health First Aid
Community action Ensure communities have opportunity to advocate for support and change related to improvements in drought situations
Settings and Supportive Environments
Organisational Development Health and community service organisations ensure they are able to respond with appropriate services provision relevant to supporting drought affected communities (eg. Counselling services available; waiting list demand management) Encourage Better Outcomes in Mental Health program to be responsive to support Drought affected clients Local emergency management processes are reviewed to ensure inclusion of supports required for incidences.
Workforce Development Conduct the VicHealth Mental Health Promotion Short Course locally for key community people involved in drought.
Resources Allocate any additional resources appropriately to support this key area.

Catchment priority organisations and their partnership role in IHP.

Shire of Campaspe:	Lead in local drought advocacy group, emergency management planning and community development initiatives
Murray Plains Division of General Practice	BoMH program General Practice support for farming communities
Community Health services - Echuca - Kyabram - Rochester	Social marketing and health information Screening and risk assessments through social work and counselling services Counselling service provision
Hospitals	Ensure staff are appropriately trained in ASSIST and Effective Follow-up of Suicidal Clients Presenting at Emergency Departments/A&E
Community Mental Health	Lead of Campaspe Murray Mental Health Network

Key action area 3 – Reducing Discrimination of Indigenous Communities

Priority Goal:	**To improve mental wellbeing and social connectedness** To reduce discrimination of Indigenous people				
Objective (s):	To build cultural identity and strengths through connectedness to culture To increase cultural awareness To build partnerships with the Aboriginal communities in Campaspe				
Est. Impacts (Qual/ Quant)	Improved cultural awareness by mainstream services Opportunities for partnerships created Opportunities for indigenous people participating in services created				
Summary of mix of Interventions	**Key implementation partners** Community Reps, Community Health, Women's Health, Local Government GPs and Divisions, Alcohol & Drug Services, Hospitals	**Population Target Group/s:**	**Estimated timelines (Optional)**	**Estimated Reach**	**Estimated intervention resources per member**
Social marketing and Health information Support media releases that promote cultural awareness					ERH: AHLO CHN 0.1 EFT BH: AS&EWO
Health education and skill development Develop and implement a Cultural awareness and service promotion program for - mainstream health and community services - general community including employers, traders, schools etc	Njernda Aboriginal Corporation Echuca Regional Health Community Mental Health	Mainstream/ general community	November 2007 – October 2008	200 staff	
Community action Work with Aboriginal Community Controlled organisation to support structured opportunities for participation within member organisations eg Shire of Campaspe; Health Services Cultural Diversity Committees	Njernda Aboriginal Corporation Echuca Regional Health			2 agencies	
Settings and Supportive Environments Mainstream services to support cultural developments eg. Recognition of culture in organisations – visual displays etc.	PCP Member organisations			8 agencies	
Estimated Total Budget per Objective : Refer to Organisational Plans					
Estimated Total Budget per Goal : $15,000					

4. Capacity building

Using the components of capacity building (organisational development, partnerships, leadership, workforce development and resources), develop interventions for building IHP capacity around each priority. You can use the optional table on the following page to format your responses to sections 4.1 to 4.4. For section 4.5, complete the table once only around **all** priorities.

Physical Activity and Nutrition

Key action area 1 – Early Years Settings

Theme	Objectives	Interventions	What would potentially be changed/different? Impacts
Organisational development	Create supportive stuctures for KGFYL implemenation and developments	Support policy, procedures and practice development Integrate KGFYL and staff allocations into organiation plans (eg. MEYP, HP Plans) Integrate actions and outcomes into council planning and developments Develop evaluation plan - Gain baseline participation rates and food intake data by target group (behaviour observation - Investigate attitudes and knowledge base of target group in relation to nutrition education of key messages 5 veg and 2 fruit; energy dense foods - Conduct audits, pre and post for; Policy; Environment, Culture - Determine skills and capacity	Integration of early years settings plans into council Municipal Early Years Plan and Community Health plans Organisation structures are supportive of policy
Partnerships	Support parnership development required to implement KGFYL	Establish relationship with primary schools and early years settings; PPP; Ante natal services Engage with settings; Support a KGFYL shire wide working group with locality based implementation groups	Protocol developed to support PCPmember involvement combines with Campaspe Early Years Network
Leadership	To support leadership roles required to implement	Provide leadership and coordination, engagement with key stakeholders	Shire lead role supported by partners

	IHP activities		
Workforce development	Provide workforce development opportunities to increase skills and knowledge in KGFYL	Develop workforce development plan for early years staff (ie, Childcare and PS teachers) – link with statewide training opportunities Provide local training opportunities and encourage sharing of programs through a KGFYL forum for Primary Schools and for Early Childhood	Knowledge and skill capacity increased for early years staff Reorienting of early years services towards Health Promotion

Key action area 2 – Workplace Settings

Theme	Objectives	Interventions	What would potentially be changed/different? Impacts
Organisational development	Provide organisational support for workplaces involved in project	Support workplaces in adopting healthy policy, procedures and practices Develop evaluation plan - Gain baseline participation rates and food intake data by target group - Investigate knowledge base of target group in relation to nutrition education of key messages 5 veg and 2 fruit; energy dense foods - Gain baseline information on absenteeism and job satisfaction survey - Conduct workplace audits, pre and post for; Policy; Environment; Culture	Workplace organisational plans reflect health promotion activtites
Partnerships	Support parnership development required to implement PA&N goals	Set up project working group Engage with workplaces; For each workplace - HR and Management - Workers - OH&S - Champions	Workplace ownership of activities

Leadership	To support leadership roles required to implement IHP activities	Provide leadership and coordination, engagement with Workplaces	Coordinated and supportive approaches delivered
Workforce development	Increase workplaces skills and abilities to support IHP practice	Investigate opportunities for providers to be trained in 'how to motivate' target group and encourage participation Skill workplaces in knowledge of IHP approaches to sustain ongoing developments	Knowledge and skill capacity of workplaces increased

Key action area 3 – Community Settings

Theme	Objectives	Interventions	What would potentially be changed/different? Impacts
Organisational development	Provide organisational support for implementation	Establish linkages with Shire of Campaspe Community Planning groups and Drought Committee Support and encourage GP practices with implementation of Lifescripts Develop evaluation plan Gain baseline fruit and veg intake data by target group Conduct availability and accessibility audit of current fruit and veg options available to target group Investigate knowledge base of target group in relation to nutrition education of key messages 5 veg and 2 fruit; energy dense foods Gain baseline participation rates by target group Conduct mapping exercise of current physical activity options available to target group and preferences	Organisations support project initaitives in workplans, ororganisational plans and relevant community plans

Partnerships	Support parnership development required to implement PA&N goals	Support the Community Settings partnership Engage with key stakeholders; Crossenvale Neighbourhood House, STEPS, Centrelink, Churches, Neighbourhood houses, Kyabram Community and Learning Centre Engage with key stakeholders; Murray Human Services, Community Living and Respite Services, Shire HACC team, Kyabram Community and Learning Centre, Campaspe College of Adult Education, Echuca Specialist School, Sport and Recreation providers, GPs and Practice Nurses	
Leadership	To support leadership roles required to implement IHP activities	Support the Community Settings leadership roles Provide leadership and coordination for the partnership group - Community Health & Shire of Campaspe Rural Access and Falls Prevention	Lead role supported by partners
Workforce development	Increase workforce skills and abilities to support IHP practice	Encourage stakeholders to increase knowledge in Food security developments Investigate opportunities for providers to be trained in 'how to motivate' target group and encourage participation	Knowledge and skill capacity increased Reorienting of services involved towards Health Promotion/ population health

Mental Health and Wellbeing

Key action area 1 - Social Inclusion for Young people

Theme	Objectives	Interventions	What would potentially be changed/different? Impacts
Organisational development	Support schools with organisational development for policy and procedure work	Contribute organisational backfill funding	Staff have resources to support the project School policies and practices are mental wellbeing oriented Bullying is addressed in organsational plans and staff performance indicators
Partnerships	Develop partnership support and approaches required for project	Partnership convenor appointed	Partnership approaches supported by those involved Partners add value and support to program goals
Leadership	Provide leadership, coordination and evaluation for program implemenation	Coordinator appointed to facilate program	Lead role supported by partners
Workforce development	Support schools with training and skill development opportunities	Encourage participation in Mental Health Promotion Short Course Support local anti-bullying training opportunites	Knowledge and skill capacity increased Reorienting of services involved towards Health Promotion/ population health

Key action area 3 – Reducing Discrimination of Indigenous Communities

Theme	Objectives	Interventions	What would potentially be changed/different? Impacts
Organisational development	Support health promotion development	Continue to support Njernda in organisational planning that responds to needs identification Identify pathway to encourage health promotion program planning and activity Support Aboriginal workforce in Health Promotion activity	*Member organisational support for more includive practices*
Partnerships	Develop partnership support and approaches required for project	Continue to develop partnership with Njernda Aboriginal Corporation and ERH	Protocol development/processess defined with Njernda

		Aboriginal Hospital Liaison Officer Establish relationship with Community Mental Health – Aboriginal Social and Emotional Welllbeing Officer Determine process/protocol for initatives that support Njernda partnerships Encourage participation in local HP Forums	
Leadership	Support leadership in cultural practices	Build cultural identity of Njernda with mainstream services Promote leadership from Aboriginal workforce in IHP practices Encourage participation and presentations at local HP Forums	Leadership supported by partners
Workforce development	Support and encourage training and skill development in IHP practices	Support the local Aboriginal workforce attendance at Mental Health Promotion Short Course Encourage uptake of PCP workforce development grants	Increased skill and knowledge of Mainstream services

PCP IHP Partnership Capacity Building Plan

Key area: To support the PCP IHP portfolio

Theme	Objectives	Interventions	What would potentially be changed/different? Impacts
Organisational development	To support and encourage organisations to create policy and practice for IHP	PCP Executive to provide coordination, facilitation and support for HP activities PCP Executive to coordinate and lead catchment planning process Support organisations to develop IHP organisational policies and position descriptions that reflect agency commitment to IHP	Continuous planning cycle implemented Integration of organisational/community plans Accountability and position description indicators developed IHP Policy development for each full member organisation

		Develop health promotion accountability in senior management /executive positions - Support implementation of IHP Partnering agreement between CHS Support non core HP member organisations to integrate HP work into organisation practice Continue monitoring of member organisations structures, support and involvement in HP Support organisations to use IHP planning template Support organisations to enhance mentoring, supervision and performance review practices Support organisations to plan for evaluation and conduct evaluation	
Partnerships	To provide networking opportunties and capacity building forums for HP practitioners	Conduct between 3 – 4 local HP forums per year that showcase local work; provide learning from experiences of others; provide case studies with problem solving and peer support; strngthen local networks; engage non-health sectors Support community participation in HP	MoU support for IHP particiation Protocol agreement developed with agencies where relevant Community Health partnering agreement mainted
	Undertake continuous improvement practices to ensure partnership approaches are supported	Apply VicHealth Partnership Analysis tool annually - develop action plan to address deficits	
		Conduct annual reviews of key portfolio and key action areas structures and terms of reference	
Leadership	Foster leadership for IHP in Campaspe	IHP portfolio organisation to support leadership and direction setting on behalf of members PCP staff and portfolio holder toadvocate	IHP leadership idenfied and supported in each full member organisation

		and promote IHP practices Encourage each member organisation to support staff leadership in IHP	
Workforce development	Support and encourage increased skills and knowledge in IHP and related acticities	Review 2004 PCP Guidelines to access IHP WD Funds Include professional development/training component in HP forums agenda Support attendance at capacity building opportunities; - the LMR Health Promotion Short Course, - Australian Health Promotion Association conference Health promotion skill assessment tool to be conducted with each CHS and IHP key priority partnership group Conduct professional development sessions on following topics; - Re-orienting services towards IHP: educating senior managers and BoM about IHP - Facilitation skills - Change management training - Strengthen evaluation processes knowledge and skills - Media relations - Public speaking - Motivation Link local needs to LM Capacity Building Plan and other PCP key areas to combine activities	80% of participating staff report knowledge and skill capacity increase

4.5 Resources – PCP IHP Catchment Resource Summary

Please fill in the table below indicating the **estimated** resource allocation for the current funding period. Indicate either the $ amount for funds made available directly to catchment partners or an approximate $ amount where PCP health promotion staff time will be the primary resource.

Estimated Integrated Health Promotion (IHP) PCP resource allocation

Capacity building components	DHS funded PCP IHP				Member contributions
	Young People	Indigenous	PA & Nutrition	CB Plan	
Partnership development	6,000		*7,500*	4,000	
Leadership	6,000	15,000	*7,500 + 6,000*		
Organisational development	6,000		15,000	6,500	
Planning for evaluation and dissemination	3,000		*12,000*		
Workforce development	5,000		*7,000 (05/06$)*		
Estimated Total PCP resource/budget allocation ** Based on per annum allocations*	$26,000 *	$15,000	$30,000 *	$10,500 *	Refer to organisations plans

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

Carry forward from 2005-06 from IHP Physical Activity goal total = $24,000 (see italics above)

PCP allocated funds to support work with Njernda Aboriginal Corporation = $15,000

PCP funds to assist in facilitation and coordination = in kind (approx $30,000)

Additional Integrated Health Promotion Resources

Funding source/project	Links to catchment priority	Funding
HALS funding	Physical Activity and Nutrition – community settings plan through older adults participation and isolated communities	20,000
Falls Prevention – Whole of Community	Physical Activity and Nutrition – community settings plan through older adults participation and isolated communities	30,000 for capacity building (WD and OD)
Kids 'Go for your life'	Physical Activity and Nutrition – early years settings plan	20,000 (including coordination and partnership work)
Totals		$70,000

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

How will the PCP facilitate and support evaluation processes conducted by the agencies around the priority?

The key PCP role for the IHP portfolio will be to implement the following;

- Monitoring system for each program for progress to be recorded against a workplan – performance indicators to be developed
- Ensure program progress communication and dissemination strategy to be developed
- Partnership/stakeholder participation is monitored, encouraged and supported by the project coordinator
- Staff work to co-ordinate their roles to ensure quality of practice, timeframes set are realistic and
- Evaluation results are used for revision and ongoing developments
- Professional development where appropriate

As referred to earlier, review and evaluation is a key part of our revised IHP structure which indicates a minimum of annual reviewing.

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

It is envisaged that each key area /objective of the above plans will develop an evaluation plan based on the 'Planning for effective evaluation resource' (DHS, 2005) process and framework. This task will be one of the initial actions for the various partnership groups and shall be led by the project coordinator for each program area. The partnership groups will define for each key strategy and action the relevant evaluation question; expected reach and impacts; the key performance indicators; the appropriate measuring tool; data source and the timing of the measurement. Monitoring and implementing the evaluation plan will be a key role of the project coordinator. This will also include an annual reporting schedule with bi-monthly monitoring to the PCP IHP portfolio.

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

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

Each of the capacity building objectives that relate to particular key areas will be included in the processes listed above.

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

The PCP IHP Portfolio will also develop an evaluation plan based on the process listed above for the specific capacity building objectives detailed on pages 26 – 28.

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

Program dissemination will be targeted at PCP member organisations as the primary group. This will take the form of communication through;

- Hard copy availability of the findings
- Website availability
- Meeting agenda items and information sharing
- Workshops presentation held at local HP forum focusing on how practitioners might use the resource in a local context

For more broader sharing of learning outcomes, dissemination will occur through the Loddon Mallee region PCP network, statewide IHP network, and Regional Health Promotion Officer.

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

Provide an overall summary or brief response to the questions set out in the guidelines about how prevention of chronic illness and addressing barriers to access and participation created by chronic illness are reflected within your IHP catchment plan.

People experiencing disadvantage and inequalities in communities throughout Campaspe are a major focus of our IHP plan for 2006 – 2009.This focus will be directed at those in rurally isolated areas, the Crossenvale neighbourhood in Echuca, those experiencing chronic disease and other groups experiencing low socio-economic status. Campaspe PCPs IHP planning process has focussed strongly on inequalities and objectives have been selected to address determinants of health – all member organisations supporting the PCP IHP plan are committed to addressing inequalities.

Many of the indicators used to ascertain key priority areas are based on disease such as the Ambulatory Care Sensitive Conditions study and Burden of Disease study. All three of Campaspe PCPs key priority areas are demonstrative of responding to chronic conditions.

Isolation is one of the broader impacts of chronic illness on people in Campaspe – this has been a major consideration in ensuring programs are delivered to outlying areas not only major centres

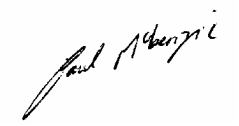
Addressing barriers to participation are key strategies for all program implementation plans and are a focus for capacity building initiatives – refer to summary of interventions. Our capacity building plan details strategies addressed for reorienting health services to drive upstream approaches.

Deliverable 3: Service Coordination

October 2006

Campaspe Primary Care Partnership

Community Health Plan

Endorsed by PCP Chair:			
Name: Paul McKenzie	Signature:		Date: 3 November 2006

Goal 1: Implement the Better Access to Services (BATS) framework by progressing common practices, processes, protocols and systems for initial contact, initial needs identification, referral, assessment and care planning by member organisations.

Objective	Strategies/Interventions	When	Stakeholders Invovled	Estimated Impact
Local Implementation of common practices, processes, protocols and systems	Support current members to improve the quality of PPPS implementation - Review member organisations progress in completing SC Implementation Plans March 06 – Dec 06 - revise Campaspe PCP benchmark audit tool to support DHS survey measures - Conduct 2nd benchmarking audit in line with DHS set audit period Statewide PPPS Implementation: - revise local protocols in response to statewide PPPS; check for duplication, synergies etc. - re-gain approval of agreed PPPS with all full member organisations through 2007 – 2009 SC Agreement - engage relevant affiliate member organisations for approval through 2007 – 2009 SC Agreement	December 2006 December 2006 – January 2007 March 2007 July 2007 – October 2007 July 2007	All full MOU Members and relevant Affiliate members MOU and relevant affiliate members	100% of MoU member organisations implementing local PPPS - adopted into agency policy and procedures 100% of relevant Affiliate members agreee to implement local protocols 100% of relevant organisations participate in benchmarking audit 100% of relevant organisations sign 2007 – 2009 Service Coordination agreement

Objective	Strategies/Interventions	When	Stakeholders Invovled	Estimated Impact
Acute/ Community/ GP interface – focus on feedback and care planning with GP to community and discharge to community	Stage 1: Investigate quality care planning models from statewide sources (ie. GPDV GP Grant learnings, statewide PPPS etc) and applicability to local PPPS.	January 2007	General Practice Division Victoria Murray Plains Division of GP	Improved care planning practices
	Benchmarking audit no. 2 to inform care planning - agencies that are leaders to mentor other agencies	Feb 2007	Service Coordination Steering Committee	
	Workforce Development/Training to be provided - Conduct local care planning forum/training session - include GP Management Plans with Team Care arrangements for Allied Health providers and provider numbers (eg. Based on case studies	January 2008		Increased knowledge and skills in care coordination implementation
	Improve communications through MPDGP Board reports and newsletters and general practice liaison - Focus on quality communications for referral, feedback and care planning - Service promotion – relationship building/trust with GPs and Clients - Provide specific program reports	Ongoing		Improved referral, feedback and care coordination practices

Objective	Strategies/Interventions	When	Stakeholders Invovled	Estimated Impact
	Partnership development – create and/or support networking opportunities that involve coordination and collaboration between general practice and member organisations - Involve general practice in ICDM program developments (refer to ICDM plan) - investigate funding opportunities that create opportunity - Service Provider groups to include/invite practice nurses Stage 2: Review local PPPS in line with flowchart to accommodate/include care planning with - Chronic Disease linkages - Discharge Planning linkages	Ongoing February 2007 – ongoing November 2007 – March 2008	Service Coordination Steering Committee	
Support for new program areas	Integrate local and statewide PPPS into new program areas practice - coincide with service uptake of SC practices Initiate measuring of SC practice for Affiliate members and other program areas by involving in Benchmarking audit in 2007 - Mental Health - PDRSS	Review every 12 months in October or as required	Affiliate members and St Lukes' Community Mental Health ERH Drug & Alcohol Murray Human Services Service Coordination	Particpation from new programs inService Coordination activities Uptake of SCTT2008 by all new program areas by 2009

Objective	Strategies/Interventions	When	Stakeholders Invovled	Estimated Impact
	- Disability - Drug & Alcohol Support new program areas in responding to SCTT2008 review - Support new profiles for; Child Protection – community based intake Early Childhood Carers Dental Palliative Care Housing	 When SCTT2008 released	Steering Committee	
Support networking for Service providers through forums and clusters	Service provider forums to support relationship building and service coordination – agenda SC at local Service Provider meetings Encourage new workers attendance and participation in Service Provider forums Ensure Council newcomer's package includes information for Service providers Orientation for Service Coordination to be included in all organisations - disseminate training package/points for inclusion - Connectingcare.com and local service directory to be available also	November 2006 – March 2007 Ongoing December 2006 – June 2007	Member organisations Shire of Campaspe and PCP Executive Officer Service Coordination Steering Committee	Enhanced partnship approaches Mentoring and support provided

Goal 2: Improve communication about clients (especially those with chronic disease and complex needs) with general practice, leading to more active GP participation with other service providers involved in the client's care.

Objective	Strategies/Interventions	When	Stakeholders Invovled	Estimated Impact
Improve communication with **GPs and support** for referral, feedback and care coordination processes	Link to ICDM strategies once ICDM established Create opportunities to communicate with GPs - conduct GP dinners with case study scenarios on specific chronic diseases/issues that reflect MBS items - commence with Mental Health - focus on 'how this is going to help my client'/ client focus Ensure member organisations provide quality feedback to GPs regarding individual clients through benchmark auditing process Encourage consumers to be involved in their own health care through - Linking you to Health Services wallet card - Member organisations community groups	July 2007 6 monthly February 2007 Ongoing Ongoing	Murray Plains Division of GP GP Practices Private practitioners including pharmacists, psychologists etc Service Coordination Steering Committee members	Enhanced relationships with general practice Level of communication improved Consumer participation in working groups

Goal 3. Successful implementation of the Victorian Service Coordination Practice Manual and subsequent versions of the Service Coordination Tool Templates.

Change management support for implementation of e-referral.

Objective	Strategies/Interventions	When	Stakeholders Invovled	Estimated Impact
Support implementation of Service Coordination Tool Templates	Full implementation of new release SCTT2006 SCTT2008 - participate in review process Revise 2007 -2009 Implementation plans to support SCTT2008 Refer also to Goal 1	By December 2006 2007 - 2009	Full MOU members and relevant affiliate members	All Mou and relevant affilate members use most recent versions of SCTT available
Improve **Electronic Referral** between GPs, community service providers and acute sector	VSRF being updated - version 2 in Medical Director - work through issues with auto populating Liaise with Practice Managers (where possible and relevant) Support electronic data transfer security needs for GP practice accreditation – due January 2009 Investigate messaging systems to support e-communication in addition to	Ongoing (every 3 years) 2009	MPDGP GPs Service Coordination Steering Committee	All GP practices have access to V2 of VSRF GP practices enabled to send and receive secure electronic transmissions

Objective	Strategies/Interventions	When	Stakeholders Invovled	Estimated Impact
	Connectingcare.com PKI capabilities within member organisations to be developed (to support GP to community communications) Review e-business rules to include PKI troubleshooting guide Conduct e-Referral training and follow-up Investigate links to LMHA to assist e-communication - through member organisations - through Service Coordination committee	By June 2007 January 2007 Early 2007 – by June 2007	Full MOU members and relevant affiliate members PCP Management Group Service Coordination Steering Committee	E-Business rules are applied by all participating e-communication organisations Key staff have skills and knowledge on e-communication practices

Goal 4. Improved amount and accuracy of information to support referral through the Human Services Directory.

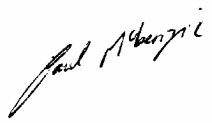
Objective	Strategies/Interventions	When	Stakeholders Invovled	Estimated Impact
Services information/ Directories – improving access for consumers	Connectingcare.com Data Administrator training - each MoU member organisation to appoint administrator - MPDGP to support GP practices	November 2006	PCP Executive Officer and member organisations administrators	Improved and accurate information provided on CCC and HSD 80% of staff know about CCC
	Confirm HSD updating process linkages to CCC - conduct CCC updating session	Annually - March 2007		
	Support service provider groups to develop locality Services Directories for; - Rochester - Echuca - Kyabram - Rushworth	January to September 2007 Annual updates	Service Coordination Steering Committee; Service Provider Networks; Consumers groups/reps	Consumers report increased kowlege on services available to access

Deliverable 4: Integrated Chronic Disease Management

October 2006

Campaspe Primary Care Partnership

Community Health Plan

Endorsed by PCP Chair:		
Name: Paul McKenzie	Signature: 	Date: 3 November 2006

All PCPs

Goal	Objective	Strategy	When	Stakeholders Involved	Planned Impact
1. Completion of a **mapping of self-management interventions** (provided by agencies within the catchment). **Facilitate planning processes** to develop self-management interventions within member agencies that **respond to gaps identified** in the mapping process.	Increase knowledge of self-management practice in Campaspe PCP	Engage project coordination and identify key stakeholders/relevant self-management services/providers Investigate evidence based practice/ interventions and strategies appropriate to mapping and gap analysis Develop partnerships required with General Practice, Division of GP and member agencies Establish appropriate governance to support coordination and management of ICDM project Conduct mapping exercise with all key stakeholders. Include identification of implementation strengths and issues Disseminate findings of mapping exercise with key stakeholders and steering committee	February 07 February 07 March 07 April – June 07 July 07 – ongoing	All PCP full members and relevant affiliate members	Year 1 50% of chronic disease practitioners have increased skills and knowledge in chronic disease management Year 2 & 3 100% of chronic disease practitioners have increased skills and knowledge in chronic disease managememt

Goal	Objective	Strategy	When	Stakeholders Involved	Planned Impact
		Determine integration opportunities for planning outcomes eg. Organisational plans; service system developments Facilitate planning process to develop response to gaps identified. Include development of 12 month implementation workplan	March 07 August - September 07		
2. Facilitation of a process for agencies to define their **roles and responsibilities**, especially acute and community health services, in relation to providing self-management interventions for people with chronic disease. 3. Successful implementation of the Better Access to Services (BATS) framework by **progressing common practices, processes, protocols and systems** for initial contact, initial needs identification, referral, assessment and care	Support member organisations to develop local/ common practices, processes, protocols and systems (PPPS) for self management of chronic and complex needs	Link evidence based review findings to local needs and approaches for intervention effectiveness – determine roles and responsibilities through development of a self-management pathway based on BATS framework Add to local PPPS and organisation Service Coordination Agreements Support organisations to improve care planning processes specific to chronic and complex needs	August 07	All PCP full members and relevant affiliate members and Service Coordination Steering Committee	Local PPPS agreements include Roles and responsibilities for self management practices Local PPPS modified to relate to people with chronic disease

Goal	Objective	Strategy	When	Stakeholders Involved	Planned Impact
planning by member agencies, particularly as it relates to people with chronic disease.					
4. Developed and defined local agreements and systems to **identify clients with chronic disease who require comprehensive assessment**, by working with PCP member agencies, particularly GPs. 5. Developed and defined local agreements and systems to **identify clients with chronic disease who require cross-disciplinary/multi-agency (including GP) care planning**, by working with PCP member agencies, particularly GPs.	As above	As above			Local agreements include comprehensive assessment and coordinating care arrangements
6. Developed and defined **local agreements and systems** around initiating and **coordinating care** planning for people with	As above	Identify key areas for GP involvement with MPDGP Ensure linkages with ERH GPs in CHS program	Ongoing	All PCP full members and relevant affiliate members and Service Coordination Steering	As above

Goal	Objective	Strategy	When	Stakeholders Involved	Planned Impact
chronic disease by working with PCP member agencies, particularly GPs.		Link with ERH HARP/CDM program, include in annual review		Committee	
7. Strengthened approaches to **address disadvantage and health equality** in Integrated Health Promotion initiatives, including **barriers to participation** such as chronic disease.	Ensure disadvantage and inequalities are considered in all IHP program developments	Conduct chronic disease focussed workforce development for health promotion practitioners and service providers Support development of health promotion intervention programs specifically targeting barriers to participation	Planning September 06 Annual review		Integrated Health Promotion plan integrates with ICDM plan Inequalities key priority for IHP programs