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INNER SOUTH EAST PARTNERSHIP
in COMMUNITY AND HEALTH

Joint PCP Strategic Plan 2013-2017

30/10/2013

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Joint Chairs' Foreword

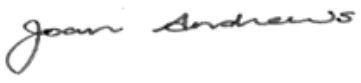
It is with extreme pride that we introduce the inaugural Strategic Plan for the new Primary Care Partnership. Primary Care Partnerships exist to enhance the health & wellbeing of local communities and to improve their access to services needed and the experience with those services. This plan will support us in our achievement of these goals over the next four years.

This document provides a backdrop to the history of both the Inner South East Partnership in Community (ISEPICH) and Health and Kingston Bayside Primary Care Partnership (KBPCP) and a direction for the new Partnership.
This Plan represents the ongoing work that has been undertaken by our many member agencies and looks to maintain the outstanding level of achievement produced by both Partnerships since their inception in 2000.
It also recognises the considerable commitment and contribution of the various workgroups, committees, agencies and the respective PCP teams through the Plan's development. It is an outstanding example of cohesive partnerships working for the future.

As two Primary Care Partnerships come together there are great challenges to align strategies and this plan is therefore a testament to the commitment and goodwill of many in this process. As merging Primary Care Partnerships we have more to do and we are acutely aware of, and committed to, the opportunity that lies before us in turning these overarching directions into an implementation plan with shared actions that are aligned across our member agencies and community.

On behalf of the Joint Executive Team, we express our gratitude to all agencies and their staff and the PCP teams for their ongoing support, commitment and individual contributions to the development of the foundation plan for the new Partnership.

We look forward to working together as one entity to deliver this, our shared Strategic Plan.



Kent Burgess
Co-Chair Joint Executive Management (former ISEPICH Chair)
Inner South Community Health Service

Joan Andrews
Co-Chair Joint Executive Management (former KBPCP Chair)
Bayside City Council

Acknowledgements

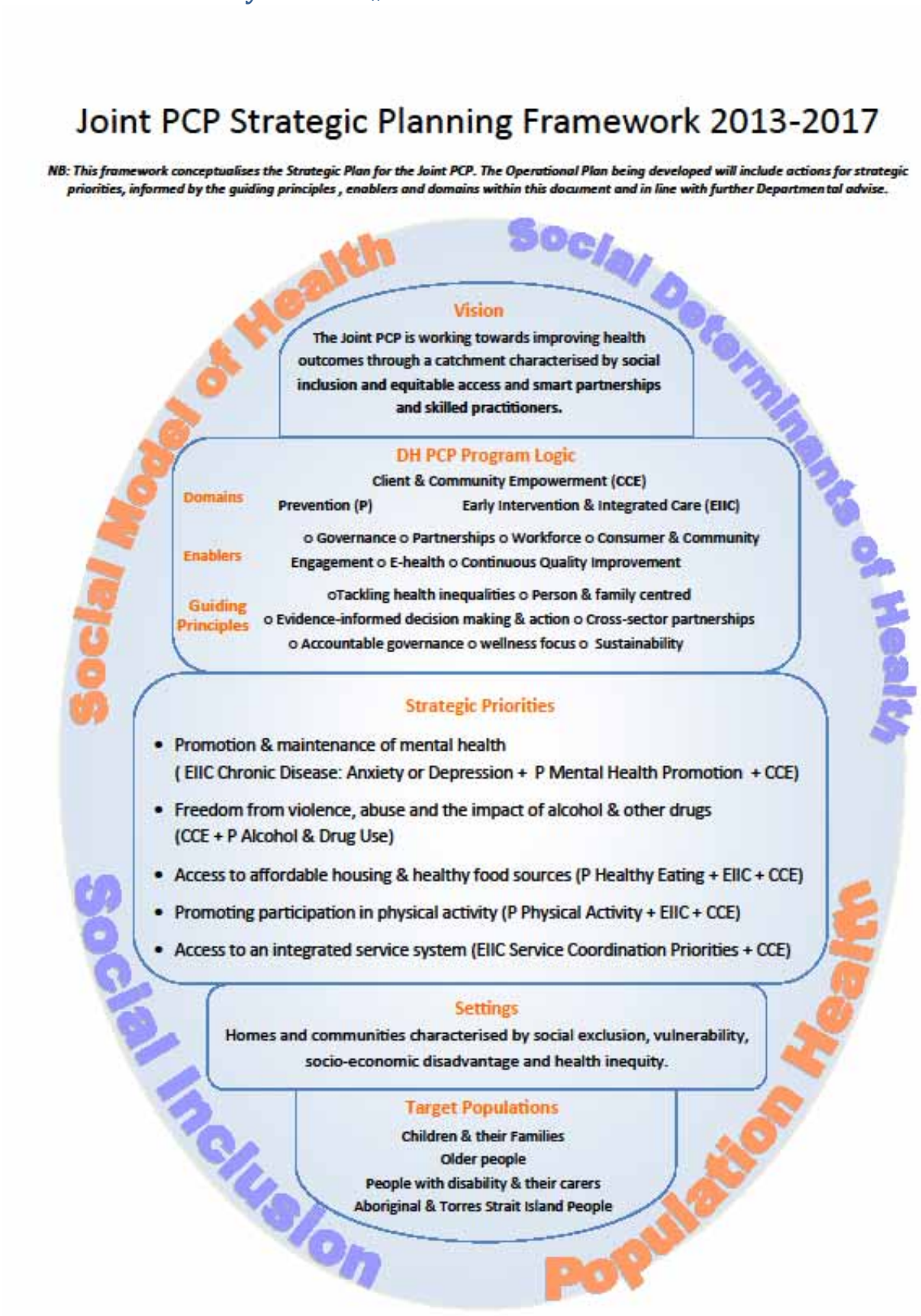
Both ISEPICH & KBPCP wish to acknowledge the traditional custodians of the land on which we and our partner agencies work, the Wurundjeri and Boon Wurrung people of the Kulin nation, and pay our respect to them, their culture and their elders past, present and future.

This document was developed jointly between the Inner South East Partnership in Community & Health (ISEPICH) and Kingston Bayside Primary Care Partnership (KBPCP). The development of this plan has been the product of considerable work, time and dedication by both PCP staff and member agencies, with a strong commitment to the partnership and collaborative planning process across two PCPs, particularly during an amalgamation phase.

Many thanks to Dr Meg Montague, whose expertise was integral in developing this document. Meg's professionalism, attention to detail, flexibility and innovation has been central to working collaboratively with both PCP teams in creating this Strategic Plan.

The PCPs also wish to acknowledge and thank all members of the community who took part in multiple community consultation processes across both PCPS, as well as the Community Advisory Group and 'Our Voices' Community Researchers.

Executive Summary



1. Introduction

The Joint Primary Care Partnership (Joint PCP) is a voluntary alliance of seventy partnership agencies, including local government authorities, health and welfare agencies and community organisations in Melbourne's inner south, south east and bayside communities. These agencies include:

- 4 community health services
- 1 regional women's health service
- 5 City Councils
- 3 hospital networks
- 1 Medicare Local
- Client and consumer agencies
- A wide range of agencies delivering services in housing, nursing, disability, youth, early childhood, respite and palliative care, drugs, alcohol and gambling, and migrant support etc.

The Joint PCP covers an area bounded by the five local government areas covering the cities of Port Phillip, Glen Eira, Stonnington, Kingston and Bayside, indicated in the map below. This area includes a population of over half a million people representing 14.1% of the total Melbourne population.

The Joint PCP is a new entity based on the merger of two existing PCPs; the Inner South East Partnership in Community and Health (ISEPiCH) in the northern part of the catchment, and the Kingston Bayside PCP (KBPCP) in the southern part. Both PCPs have been in operation since the establishment of PCPs in Victoria in the year 2000.

Up to the merger, KBPCP operated under the auspice of Central Bayside Community Health Centre and was supported by two advisory groups: Integrated Health Promotion and Service Co-ordination/ Integrated Chronic Disease Management. It had an overall membership of around 25 agencies. ISEPiCH operated under the auspice of the City of Port Phillip with three advisory groups: Service Co-ordination and Integrated Chronic Disease Management, Health Promotion Prevention & Population Health, and a Community Advisory Group of consumer representatives. ISEPiCH membership included nearly 60 health, welfare and community support organisations.

1.1 The merger

The decision to merge the two PCPs was made in 2013 in order to co-ordinate regional and local planning in recognition of the overlap of the work of many of the member agencies. A merger was also seen as a means of making the most effective use of available funds and of recognising the opportunities arising from the establishment of the Bayside Medicare Local across identical boundaries (as illustrated in the map above).

Planning for the merger has been extensive. Discussions were originally held over 5 years ago, but were not pursued at that time. In mid-2012, a survey of members of both PCPs strongly supported the concept of a merger and by mid-2013 the Executive Committees of the two PCPs began the detailed planning process that would result in a finalised merger by mid-2014. This process is outlined below:

- A Joint Executive Management (JEM) Committee was formed consisting of the Executive Committees of both PCPs with the role of overseeing the planning for the merger.
- A Transition Group was established consisting of the Chairs and Deputy Chairs of the two PCPs. This Group was tasked with managing the implementation of the merger. The existing Executive Officers of both PCPs also attend this Committee.
- Each PCP's separate Health Promotion Committee (HP) and Service Co-ordination /Integrated Chronic Disease Management Committee (SC/ICDM) merged to form one Joint HP Committee and one Joint SC/ICDM Committee.
- The ISEPiCH Community Advisory Group does not have a Kingston Bayside equivalent so no changes have been made to date in the structure of this committee.
- At the Department of Health's request, a Business Case was undertaken detailing governance, budgetary, management and implementation issues. Once formal agreement is obtained from the Department of Health, the intention is for a Joint PCP Executive Officer to be appointed by early 2014 and full amalgamation to follow from July 1st 2014.
- During September and October 2013, the Transition Group, the Community Advisory Group, the Joint HP Committee and the Joint SC/ICDM Committee provided feedback on a first and then a second draft of this strategic plan. In October this plan was endorsed by the Joint Executive Committee.

The Joint PCP Strategic Plan has been developed in the midst of this change period for delivery to the Department of Health by the deadline of October 31st 2013. The Plan is based on an evaluation of the past PCP health and wellbeing priorities, a review of state and federal government priorities, the development of a comprehensive catchment wide evidence base and extensive consultation with the community and the membership during the first half of 2013. Details of these activities are contained in section 3 of this document.

1.2 This document

This document represents a summary of the basis for, and the scope of, the vision and strategic priorities adopted by the Joint PCP for its work over the next four years, 2013-2017. The document briefly explains the policy and planning context within which these priorities were adopted; the process used to develop them; the rationale for adopting the priorities and their objectives; and suggests the potential focus for PCP member agency actions that will be reported on in a detailed Operational Plan in early 2014.

1.3 The value base

The work of the Joint PCP is underpinned by a commitment to provide leadership to strengthen collaboration and integration across sectors in order to maximise health and wellbeing outcomes and to promote health equity for all those who live and work in the catchment.

To support this collaborative, partnership and integrated approach, the PCP works within a framework that emphasises

- Population health thinking derived from a number of models and frameworks that all recognise the impact of social, economic, cultural and political factors on health and wellbeing and the need to focus on these as well as biological and medical factors when striving to improve health and wellbeing and reduce the burden of disease
- A focus on health equity and reducing health inequalities
- Joint planning and action informed by the best available evidence
- The adoption and implementation of planned actions that are appropriate, assessable and achievable

- Continuous sharing of information and working co-operatively
- Working inclusively and sensitively to communicate with and hear from clients and community members, agencies and their workers
- Recognition of the diversity of the service system, the communities in which we work and the skills and knowledge of members
- Working with both a catchment wide perspective AND a focus on the issues affecting particular communities and populations in specific locations.

2. The Policy and Planning Context

This Joint PCP Strategic Plan has been developed within the context of national and state policy directions for the health and wellbeing of the Australian and Victorian community. This Plan is also informed by the Department of Health *Primary Care Partnership Program Logic 2013 -17*[1] and by a number of closely aligned guidelines for local government, community and women's public health planning. It is also informed by a range of theory, models and frameworks for thinking about health: these are summarised below.

2.1 The National context

A National Health Reform Agreement was signed by the states and territories on 2 August 2011. This agreement is accompanied by eight schedules that outline the new arrangements under the reforms:

- Sustainability of funding for public hospital services
- Establishment of national bodies
- Transparency and performance
- Local governance
- General practice and primary health care
- Aged care and disability services
- Business rules
- Future work plans.

For further information go to http://www.health.vic.gov.au/news/health_reform-2011.htm

Medicare Locals (MLs)

A component of the Reform is the establishment of Medicare Locals across Australia to ensure high-quality primary care is provided in each area and is co-ordinated to meet local needs. There are 17 Medicare Locals in Victoria which operate to ensure that care is better integrated and is responsive to the needs and priorities of patients and communities. The intersection of the goal of MLs and PCPs provides an opportunity to ensure that our work is complementary. More information can be found at http://amlalliance.com.au/

National Partnerships Agreement on Preventative Health

The National Partnership Agreement on Preventive Health (NPAPH) was announced by the Council of Australian Government in November 2008 and in 2012 was extended to June 2018. The NPAPH targets the growing prevalence of chronic diseases such as diabetes and heart disease by working to embed positive health behaviours in schools, workplaces and communities. More information can be found at http://www.preventativehealth.org.au/

National Health Priority Areas were first articulated in 1996 and have since been added to, most recently in 2012 with the addition of dementia. They now include:

- cancer control
- cardio-vascular health
- injury prevention and control
- mental health
- diabetes mellitus
- asthma
- arthritis and musculoskeletal conditions
- obesity
- dementia.

Further information is available at: http://www.aihw.gov.au/national-health-priority-areas/

[1] *Department of Health, 2013, Primary Care Partnership Program Logic 2013-17 Source: www.health.vic.gov.au/pcps/about.prr.htm*

A National Primary Health Care Strategic Framework was released in mid-2013 with the goal of achieving a safe, equitable, effective and sustainable health care system. This framework focusses on four strategic outcomes

- building a consumer focussed and integrated primary health care system
- improving access and reducing inequity
- increasing the focus on health promotion and prevention, screening and early intervention
- improving quality, safety, performance and accountability

Further information can be found:
www.health.gov.au/internet/publications/publishing.nsf/content/nphc-strategic-framework

2.2 The Victorian context

The Victorian Health Priorities Framework 2012-2022 articulates the long term planning and development priorities for Victoria's health services throughout the next decade. This framework includes a State Health Plan for all Victorians and identifies seven priority areas:

- developing a system that is responsive to people's needs
- improving every Victorian's health status and experiences
- expanding service, workforce and system capacity
- increasing the system's financial sustainability and productivity
- implementing continuous improvements and innovation
- increasing accountability and transparency
- utilising e-health and communications technology.

Further information can be found at: http://www.health.vic.gov.au/healthplan2022/

Victorian Public Health and Wellbeing Act 2008

The Victorian Public Health and Wellbeing Act moved municipal public health planning from a three-year to a four-year planning requirement, aligning the planning cycle of Municipal Public Health and Wellbeing Plans with Council elections and Council Plans. Further information can be found at: http://www.health.vic.gov.au/phwa/

Victorian Public Health and Wellbeing Plan 2011-2015 (VPHWP)

The VPHWP gives a high-level view of the scope of preventive health activity in Victoria and sets the prevention agenda for the state for 2011-15. The VPHWP highlights nine priority conditions and nine priority issues for promoting the health of Victorians. Further information can be found at : http://www.health.vic.gov.au/prevention/vphwplan

Priority Conditions	Priority Issues
Arthritis	Increase healthy eating
Heart Disease	Increase physical activity
Cancer	Control tobacco use
Osteoporosis	Improve oral health
Stroke	Reduce misuse of alcohol & other drugs
Diabetes	Promote sexual & reproductive health
Depression/Anxiety	Promote mental health
Respiratory conditions (including COPD and asthma)	Prevent injury
Renal conditions	Prevent skin cancer

The Victorian Health Promotion Foundation, known as VicHealth, works with organisations, communities and individuals to make health a central component of people's daily lives. Its activity is geared towards promoting health and preventing ill health. VicHealth has recently released its *Action Agenda for Health Promotion* which outlines its three year priority areas with a broader ten year vision for 2013-2023. These priority areas closely align with the Victorian Health Promotion Priority Issues as outlined above

- promote healthy eating
- encourage regular physical activity
- prevent tobacco use; prevent harm from alcohol
- improve mental wellbeing.

More information can be found at http://www.vichealth.vic.gov.au/Publications/VicHealth-General-Publications/VicHealth-Action-Agenda-for-Health-Promotion.aspx

Victorian Government Department of Health

This 2013-17 planning cycle is the first occasion on which all local governments, community health organisations and women's health organisations across Victoria, along with PCPs have a congruent planning cycle. New program logic, planning and reporting guidelines have been mandated by the Department of Health in these fields.

Primary Care Partnership: Program Logic 2013-2017

This document establishes the planning, policy and implementation context for PCPs (see Appendix 7). The document articulates

- *The goal of PCP work* – to strengthen collaboration and integration across sectors by 2017 in order to maximise health and wellbeing outcomes, promote health equity and avoid unnecessary hospital presentations and admission
- *Seven guiding principles* - tackling health inequities, person and family centred, evidence based and evidence informed decision making and action; cross sector partnerships; accountable governance; a wellness focus and sustainability
- *Three key domains of activity* - client and community empowerment; prevention, and early intervention and integrated care. These domains are a refocus of the terms integrated health promotion and service co-ordination/ integrated chronic disease management.
    - *Consumer and community empowerment* is "for consumers, carers and community members to be meaningfully involved in decision making about health planning, care and treatment and the wellbeing of themselves and the community" (PCP Program Logic 2013: 9).
    - *Prevention* is "to work with Victorians, particularly with the most disadvantaged, to maximise their health and wellbeing, reduce the prevalence of risk factors and increase prevalence of protective factors through focusing on local partnership priority health and wellbeing issues." (PCP Program Logic 2013: 11)
    - *Early intervention and integrated care* is "to strengthen the primary health system to deliver person centred and accessible early intervention and integrated care that aims to keep people as well as possible for as long as possible, particularly people with complex care needs." (PCP Program Logic 2013: 6)
- *Six "enablers"* - governance, partnerships, workforce, client and community engagement, e-Health and continuous quality improvement.

More information can be found at: http://docs.health.vic.gov.au/docs/doc/Primary-Care-Partnership-Program-Logic-2013-17

Community Health Integrated Health Promotion Program: Planning Guidelines 2013-2017.

This document outlines the program logic and planning requirements to be met by agencies funded through the Community Health Integrated Health Promotion Program and as such has relevance to PCP planning. Agencies are urged to adopt a limited number of priority issues (i.e. 1-3) and to do this within their capacity and in the context of the state priority health issues defined in the Victorian Public Health and Wellbeing Plan 2011-2015.

The Guide to Municipal Public Health and Wellbeing Planning 2013-2017 outlines what is required in the development of the local government health and wellbeing plans http://www.health.vic.gov.au/localgov/municipal-planning.htm

Koolin Balit - the Government's strategic directions for Aboriginal health over the next decade, 2012-22. The Government intends to focus on six key priorities:

- a healthy start to life
- a healthy childhood
- a healthy transition to adulthood
- caring for older people
- addressing risk factors
- managing illness better with effective health services.

More information can be found at http://www.health.vic.gov.au/aboriginalhealth/koolinbalit.htm

2.3 Ways of thinking about health and wellbeing

The Joint PCP view of health is aligned with the **World Health Organisation** definition of health as "a complete state of physical, mental and social wellbeing, not merely the absence of disease or infirmity"[2] and with the **social model of health** that sees improved health and wellbeing as being achieved by a focus on the social and environmental determinants of health, in tandem with biological and medical factors[3]

As a Joint PCP we work with an understanding of the **social determinants of health** that recognise the conditions in which people are born, grow, live, play, work and age shape the health and wellbeing of a community, and with a **population health perspective** that reflects our understanding that the influences on health occur in the events and the settings of everyday life. These elements are illustrated in Figure 1 below[4].

Wilkinson and Marmot[5] identified ten social determinants of health (see below) and suggested that the single strongest predictor of health is position on the 'social gradient'; whether income, education, place of residence or occupational measures are used, those at the top of the gradient on average live longer and healthier lives. Those at the bottom usually run at least twice the risk of serious illness and premature death.

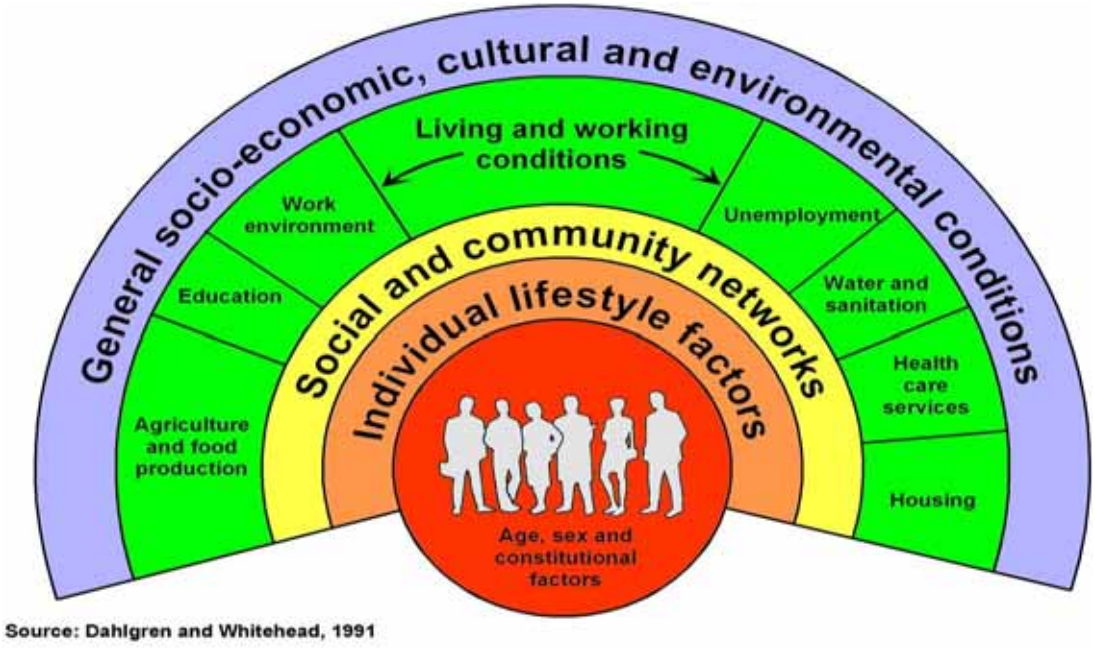
- the social gradient
- stress
- early life
- social exclusion
- work
- unemployment
- social support
- addiction
- food
- transport

[2] World Health Organisation, 1948, Definition of Health, WHO, source: http://www.who.int/about/definition/en/print.html

[3] Vichealth,n.d., Defining Health Promotion, source: . http://www.vichealth.vic.gov.au/Publications/VCE/Defining-health-promotion.aspx

[4] Kindig, D and Stoddart, G, 2003, What is Population Health?, American Journal of Public Health, Vol 93, issue 3, pg 380-383, source: . http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447747/

[5] Wilkinson R. Marmot M. eds. The social determinants of health. The solid facts 2nd edition. 2003 WHO



Source: Dahlgren and Whitehead, 1991

The PCP Program Logic 2013-2017 identifies 13 social determinants of health as factors influencing the health and wellbeing of individuals and communities:

- early years
- education including literacy
- food security
- employment and working conditions
- income
- housing
- transport
- social inclusion and participation
- gender equity
- beliefs and values
- health literacy
- welfare support systems
- racism and discrimination

The Joint PCP is also informed by the **Environments for Health** framework, which is the framework used in the development of many municipal public health and wellbeing plans. This framework is used to advance public health and wellbeing by focusing on actions across four environments – the social, economic, built and natural environments.[6]

Social Inclusion theory also has its place in our way of thinking about health. As indicated above experiences of poverty and poor health are inextricably linked and international research has consistently indicated that people from lower socio-economic groups are more likely to suffer ill health than wealthier citizens.

> *Many Australians are excluded from the opportunities they need to create the life they want, and can become trapped in spirals of disadvantage caused by family circumstances, low expectations, community poverty, a lack of suitable and affordable housing, illness or discrimination – often leading to leaving school early, long-term unemployment and chronic ill-health. Some people are at greater risk of multiple disadvantages, such as jobless families, Aboriginal and Torres Strait Islander people, people with disability and mental illness,*

[6] *Department of Human Services. 2001, Environments for Health: Promoting health and wellbeing through built, social, economic and natural environments. Municipal Public Health Planning Framework. State Government Victoria.*

vulnerable new migrants and refugees, those with low incomes and people experiencing homelessness. The costs of this social disadvantage are high – to individuals, communities and the nation. Australian Social Inclusion Board[7]

The Australian Social Inclusion Board (ASIB) has adopted a number of priority areas under their **2010 Social Inclusion Plan** that bear a close similarity to the areas identified by our stakeholders as critical to the health of residents in the catchment:

1. Improving the life chances of children at the greatest risk of long term disadvantage
2. Helping jobless families with children to increase work opportunities, improve parenting and build capacity
3. Reducing the incidence of homelessness
4. Improving outcomes for people living with disability or mental illness and their carers
5. Closing the gap for Indigenous Australians
6. Breaking the cycle of entrenched and multiple disadvantage in particular neighbourhoods and communities.

The ASIB published a baseline document (2010) and a report on progress in 2012. Social inclusion is assessed against indicators of three key concepts (2012:14) multiple disadvantage, resources and participation. These indicators are reproduced in detail in Appendix 8, and it can be seen that they encompass the social determinants of health including early child development, income, housing, transport, education, health literacy, social participation, safety in the home and the community, disability and mental health. This broad understanding of social inclusion is the one the Joint PCP has adopted.

[7] *Social Inclusion in Australia: How Australia is Faring 2nd Edition 2012. Australian Government. Department of Prime Minister and Cabinet*

3. The Development of the Strategic Priorities

3.1 Continuity with past PCP and present government priorities

The strategic planning process involved not only a scrutiny of the state and federal government frameworks and priorities discussed above, but also a review of the PCP priorities for 2009-12.
In 2009, the KB Strategic Plan identified six priority areas for the period 2009-2012

- Stronger partnerships
- Better access to services
- Improving care for people with chronic disease
- Mental health and wellbeing
- Accessible and nutritious food
- Physical activity and active communities

The 2009-2012 ISEPiCH Strategic Plan identified four priorities:

- Social inclusion and inclusive communities
- Better access to services
- Sustainable and affordable living and environments
- Care for people experiencing chronic disease including diabetes and mental illness

3.2 A detailed evidence base

The Joint PCP has developed a comprehensive Population Health Atlas Planning Resource[8] in order to provide a shared, evidence informed approach to priority setting and strategic planning. The Atlas includes detailed demographic data, social, health and wellbeing indicators, and highlights that there are notable differences in the economic and social circumstances of residents in each LGA and in particular suburbs; for example, some areas combine wealthy populations alongside pockets of significant disadvantage. (For more information see www.portphillip.vic.gov.au/about_isepich.htm). The Atlas enables the identification of specific locally identified disadvantaged and/or marginalised population groups, to be cross referenced with priority issues or conditions, and has been valuable in informing the development and adoption of the strategic priorities for action.

3.3 Consultation with PCP members and the catchment community

A wide range of consultative activities informed the priority planning process. These included

- Seven face-to-face forums organised by the two PCPS with their members
- Several on-line surveys with partnership members
- Participation in a wide range of community and agency consultation overseen by local government as part of their public health and wellbeing planning process. This was especially evident in the Kingston Bayside catchment
- Discussion and refinement of the draft priorities by PCP members and the advisory and management groups.

[8] *ISEPICH, May 2013, Population Health Atlas Planning Resource, A catchment-wide evidence base to inform 2013-17 strategic population health planning for ISEPiCH and its members.*

3.3.1 ISEPiCH

ISEPiCH organised a half day, joint health promotion and service co-ordination/ integrated chronic disease management Forum - "*Tell us like it is"* in May 2013 which was attended by 50 individuals from 38 agencies and by members of the Community Advisory Group. PCP Members were surveyed prior to the Forum to identify what they felt were the critical issues for the PCP to address over the next four years. Their responses were analysed and these, combined with the Population Health Atlas data, suggested four themes in the health and wellbeing of the community. These four themes were used as the framework for the Forum consultation and are described in detail in Appendix 3. They were:

- disparity, equity and access
- lifelong health and wellbeing
- mobility and independence
- safety, support and engagement

The Forum participants were provided with the Population Health Atlas prior to the forum, were also given a snapshot of the data about the catchment derived from the Atlas, and were then asked to discuss each theme in small working groups and to record responses to the following questions:

- What are the critical issues for the community's health and wellbeing under this theme?
- What partnership or working together opportunities there are for us to address these issues together?
- What is needed to help us work together better?

Four critical issues emerged from the analysis of these recorded responses:

- The need to work at building smart partnerships to ensure that catchment agencies work well together to build partnership projects and approaches that best meet the needs of the community and potential clients.
- The need to enhance practitioner capacity to ensure workers in catchment agencies have the knowledge and skills to engage with clients and consumers and involve them in the design and implementation of prevention, early intervention and integrated care strategies.
- Concern about the health and wellbeing of children and their families and about a range of determinants of their health such as mental health, access to adequate income, safe housing, healthy food and appropriate support services, participation in education, physical activity opportunities and community life, safety from violence, abuse and the impact of alcohol and drugs.
- Concern about the health and wellbeing of two other critical population groups: older people and people living with a disability. Again a social inclusion and social determinants focus combined to raise issues around mental health, access to adequate income, safe housing, healthy food and appropriate support services, participation in physical activity opportunities and community life, safety from violence, abuse and the impact of alcohol and drugs.

The ISEPiCH Community Advisory Group (CAG) were also consulted throughout the development phase of the strategic planning and have been engaged in the drafting of this document, with members also present at the Forum. Additionally, community consultation data from partner agencies were included in the Population Health Atlas and several community researchers also participated at the Forum.

3.3.2 Kingston Bayside PCP

From late 2012 to mid- 2013 the Cities of Kingston and Bayside engaged in an extensive Municipal Public Health and Wellbeing planning process which overlapped with and was supported by the KB PCP. The results of these consultations were fed into the PCP planning process. At Kingston methods included

- A review of other local government public health and wellbeing plans and related strategies and the current policy and planning context
- Analysis of health and wellbeing data in Kingston
- Community consultations including telephone survey with 512 residents and more than a dozen workshops with community and key council stakeholders

More information can be found in the City of Kingston Public Health and Wellbeing Plan 2013-2017 at www.kingston.vic.gov.au

At Bayside methods included

- Evaluating previous plans and reviewing the current policy and planning context
- Conducting a telephone survey of 400 residents regarding health issues and behaviours
- Developing a local comprehensive health and demographic profile
- Workshopping themes with Council Departments and key stakeholders
- Consulting with over 650 Bayside residents, services and organisations covering all ages and abilities.

A copy of the Wellbeing for All Ages and Abilities Strategy, the Health Profile and the Community Engagement Report can be found at www.bayside.vic.gov.au

KBPCP then held a two-stage consultation process with key stakeholders in the catchment. *Stage One* involved a half day Forum in March 2013 to identify the health and wellbeing priorities for the PCP over the next four years. The Forum was attended by 47 people from 18 agencies: four health and wellbeing priorities were identified and prioritised as follows:

1. Promoting mental health and wellbeing
2. Promoting physically active communities
3. Promoting safe communities
4. Promoting healthy eating and food security

A Stage Two consultation was held in June 2013 consisting of four 2 hour workshops each focusing on one of the four health promotion priorities identified in Stage One. Forty three people attended these sessions. Out of these detailed discussions, two key health promotion priorities emerged as critical to encompass the four previously identified priorities:

1. Healthy lifestyles (focus on food and physical activity)
2. Inclusion and engagement (focus on mental health and a safe community)

4. The Joint PCP Strategic Framework 2013-2017

The data analysis, evidence gathering and consultation processes together with the policy, planning and conceptual frameworks detailed in Section 3 have led the Joint PCP to adopt the following strategic framework to guide its work over the next 4 years (see a summary of the framework in the executive summary). This framework, together with the operational or action plan currently under development with the member agencies, indicates how the Joint PCP intends to fulfil the Department of Health goal for PCPs *"To strengthen collaboration and integration across sectors by 2017 in order to maximise health and wellbeing outcomes, to promote health equity, and to avoid unnecessary hospital presentations and admissions"*

4.1 The overall vision

Our vision is of a catchment community characterised by **social inclusion and equitable access** where vulnerable and disadvantaged populations who experience social exclusion and multiple disadvantage, live in healthy, safe and resourced homes and community settings that minimise risk and maximise protective factors for health and wellbeing.

Our vision also includes a PCP that operates with **smart partnerships and skilled practitioners** who have enhanced capacity to work collaboratively across sectors and to engage clients and communities in planning and delivering affordable, accessible, evidence informed and culturally sensitive supports and services.

4.2 The strategic priorities

The Joint PCP has adopted five strategic priorities for action that have been identified as critical to the achievement of this vision.

1. The promotion and maintenance of mental health
2. Access to secure and affordable housing and healthy food sources
3. Promotion and support for participation in physical activity
4. Freedom from violence, abuse and the impact of alcohol and other drug use.
5. Access to an Integrated service system

The adoption of these strategic priorities is informed by

- The literature around the social determinants of health and the social model of health which indicates that many of the issues affecting the health and wellbeing of the community such as depression, anxiety, inactivity, poor eating habits, drug and alcohol use and violence are associated with social exclusion and marginalisation, and that the most vulnerable individuals and communities tend to be characterised by multiple and entrenched disadvantage.
- The statistical evidence contained within the *Population Atlas*, and the local level data collated by local government as part of their municipal public health and wellbeing planning processes indicate that the Joint PCP catchment is marked by areas of inequality with residential pockets where people experience significant disadvantage.
- Continuity with the priorities of the 2009-2012 ISEPiCH and KB strategic plans both of which explicitly included a commitment to increasing social inclusion and strengthening community and agency capacity to address the determinants of health.
- Our belief that partnerships and skilled practitioners are the core of PCP work, however there are significant challenges in building an integrated and co-ordinated network of agencies and workers across any catchment. Empowerment of consumers and community cannot occur without skilled and committed practitioners. A newly amalgamated body such as the Joint PCP faces additional challenges and thus requires a specific focus on partnership building.

- The links between the five priorities and the Department of Health PCP priorities and domains. These are summarised below in Tables 1 and 2. In addition, the priorities are linked to the priorities adopted by the five Municipal Public Health and Wellbeing Plans (see Appendix 5).

Table 1: Joint PCP Strategic Priorities and DH PCP EI, IC and Prevention Priorities

PCP Early Intervention & Integrated Care Priorities	PCP Prevention Priorities
Major chronic disease Depression and Anxiety **Service co-ordination priorities** Referral pathways and co-ordination of services for the target populations nominated below	• Healthy Eating • Physical Activity • Alcohol and Drug Use • Mental Health Promotion
Target populations 1. Children and their families 2. Older people 3. People with a disability and their carers 4. Aboriginal and Torres Islander People With particular emphasis on people from culturally and linguistically diverse backgrounds and people living with homelessness. Awareness that these target populations are non-discrete.	
Settings Homes and communities characterised by social exclusion, vulnerability, social-economic disadvantage and health inequity.	

Table 2: Joint PCP Strategic Priorities and PCP Program Logic Domains

Joint PCP Strategic Priorities	PCP Program Logic Domains		
	Prevention/ health promotion	Consumer and community empowerment	Early intervention/integrated care/service co-ordination
Promotion and support of mental health	X	X	X
Access to affordable housing and healthy food sources	X	X	
Participation in physical activity	X	X	
Freedom from violence and the impact of alcohol and other drug use	X	X	
Access to integrated service system		X	X

As indicated above, actions will be developed across the five strategic priorities in relation to the following specific domains.

- *consumer and community empowerment* as a component of all five priorities
- *a prevention or health promotion focus* will be evident in the relation to mental health, accessible and affordable housing and healthy food, participation in physical activity and freedom from violence and the impact of alcohol and other drug use
- *an early intervention and integrated care* focus will be evident in relation to mental health and access to an integrated service system.

4.3 Focus of our actions as a newly merged entity

The Joint PCP intends to focus its planned action in relation to the five strategic priorities and their domains in ways that will help build a catchment characterised by smart partnerships and skilled practitioners as well as by social inclusion and equitable access.

These actions will be informed by the following PCP guiding principles:

Tackling health inequities

- Joint PCP will adopt actions that address social, economic and health inequities which tend to be mutually reinforcing and result in multiple and entrenched disadvantage of both individuals and communities. Examples of such population groups and individuals include Aboriginal and Torres Strait Islander communities, people living in poverty or without a secure home, and people living with a disability or a chronic disease.

Person and family centred

- Our actions will be developed with reference to research data and practice wisdom that indicate that *children* are affected by the physical, social and economic circumstances of their families. Children in families experiencing homelessness, who have a parent with a mental illness or a family characterised by violence and abuse, children in families with a low or inadequate income and insecure housing tend to experience poor physical and mental health, low levels of physical activity, poor eating habits, be overweight or obese, and have low levels engagement in education, sporting and community activities. With an early childhood start like this, children are more likely to grow into adults who are in poor physical and mental health and whose life is characterised by marginality, exclusion, vulnerability and disadvantage. It is critically important to ensure that action is taken to work with children and their families to reduce the risk of such a future.

- Actions will also be informed by the research data and practice wisdom that indicate that many *older people and people with disability* find the experience of ageing and living with a chronic health issue extremely challenging. These individual and family circumstances tend to be characterised by unequal access to income, housing, transport, services and supports when and where they are needed. Members of these groups can become isolated and marginalised, vulnerable to mental illness, poor nutrition, and limited participation in community activities such as physical activity and may receive inadequate care and support and find it difficult to access the services they need.

Evidence based and evidence informed

- Our actions will be informed by the high level indicators defined by the Australian Social Inclusion Board as well as a wide range of program performance indicators that will guide us in selecting which interventions and actions to adopt. An example could be to explore the evidence base for specific engagement strategies to support older people to participate in physical activity.

Cross sector partnerships

- Actions will emphasise the interrelationships between disadvantage, health and wellbeing, thus bringing together areas traditionally seen as being in unconnected such as welfare and public health, housing and mental health, early childhood services and food security. New partnership opportunities are suggested by this focus.

In addition the following PCP enablers will inform our action planning:

Partnerships:

- Actions to improve the partnering and collaboration capacity of member agencies (and other agencies as appropriate), understanding one another's systems and the development of collective advocacy around critical issues as appropriate

Workforce:

- Actions to enhance relationships and communication between partner agencies, including the development of professional and personal links based on face to face contact with one another via mentoring, internships, cross agency placements, staff swaps and shared professional development opportunities
- Actions to enhance the capacity of member agency staff to access and utilise appropriate statistics, evidence, best practice data in health promotion and service co-ordination.

Client and community engagement

- Action to increase sensitivity and responsiveness to client and community needs and develop skills in community and client engagement.

e-Health

- Action to support work towards joint referral and /or assessment pathways, how best to use, access or understand other's systems and pathways and to develop compatible technology and build up e-communications with one another.

Continuous quality improvement

- Action to enhance quality assessment/ evaluation and monitoring skills, to enhance the sharing of best practice examples, performance monitoring indicators etc and to utilise statistics and evidence that can inform planning and practice.

4.4 Where to from here

This high level strategic plan provides the framework for the development of an Operational Plan to guide the on-the-ground work of the Joint PCP over the next year. This operational plan is currently under development: each of the strategic priorities will have one or more objectives; each of these objectives will in turn have a number of actions.

The Joint PCP recognise the investment in time and energies required to work collaboratively in partnerships, where ownership is crucial. The Joint PCP committees are currently working on these and it is anticipated that the Operational Plan will be available in early 2014.

APPENDICES

Appendix 1 Members of the Joint PCP

AccessCare Southern
Alfred Health
Arthritis and Osteoperosis Victoria
Australian Multicultural Community Services
Baker IDI Heart and Diabetes Institute
Bayside City Council
Bayside Medicare Local
Bentleigh Bayside Community Health
Better Hearing Australia (Victoria)
Cabrini Health
Calvary Health Care Bethlehem
Caulfield South Community House
Central Bayside Community Health
Christ Church Mission
City of Glen Eira
City of Port Phillip
City of Stonnington
Community Information Glen Eira Inc
Connections Uniting Care
Do Care
Family Life
Fronditha Care
Gamblers Health Southern
Griefline
Grow
Hanover Welfare Services
HomeGround Services
Inclusion Melbourne
Inner Eastern Local Learning & Employment Network
Inner South Communication Service
Inner South Community Health Service
Jewish Care
John Macrae Centre
Joint Councils Access for All Abilities
Kingston City Council
Kingston U3A
Kosher Meals on Wheels Association
Learn for Yourself
Marillac
MECWA Community Care
Mental Illness Fellowship Victoria
Middle South Primary Mental Health Team
Mind Melbourne Middle South
Moira
New Hope Foundation
Napier Street Aged Care Services
Polish Community Council Victoria
Port Melbourne Neighbourhood House
Port Phillip Community Group
Prahran Mission
Royal District Nursing Service
Russian Ethnic Representative Council of Victoria
Sacred Heart Mission St Kilda
School Focussed Youth Service
South Eastern Centre Against Sexual Assault
South Port Day Links
South Port Uniting Care
Southern Health
St Kilda Gatehouse
St Kilda Legal Service Co-Op
St Kilda Uniting Care
Taskforce
The Salvation Army
Vision Australia
Wesley Do Care
Women's Health in the South East
Youth Connect

Appendix 2 Committees and Office Holders

Joint Executive Management Committee

Beige Pureau
Chris Fox
Chris Hill
Elizabeth Deveny
Gaye Stewart
Greg Nott
Jacqui McBride
Joan Andrews - *Chair*
John Ashfield
John Weaver
John Turner
John Wise
Judy Hamann
Judy Reeves
June Gray
Kent Burgess - *Chair*
Laura Newstead
Lynda Stewart-Wynd
Mark Saunders
Mary Riley
Michele Leonard
Peter Kalathis
Ray Blessing
Rob Crispin
Robert Seifman
Sally Howe
Susan McDowell
Susan Glasgow
Terry Lazzarotto

Joint Health Promotion Committee

Andrea Wittick
Annette Forde
Barbara Ryan
David Godden
Felicity Vise
Freda Goldberg
Gemma Smoker
Helena Bishop
Ian Robinson
Jacqui Goy
Jane Cheong
Jill Day
Kristine Hill
Laura Newstead
Leah Vannan
Mark Stockton
Mary Riley- *Chair*
Melissa Yong
Nicole Malina
Peter Kalathis
Ruth Knight
Sean Rayner
Shirlene Jayasundera
Sue Moulton
Susan Heywood
Susan McDowell
Terry Lazzarotto
Tess Angarane
Tracey Collins
Warrick Fenner

Joint SC/ICDM Steering Committee

Anna Thomas
Brennan Carlson
Chris Hill - *Chair*
Claire Parks
Debra Barrow
Florence Burgerhout
George Robinson
Georgia Pernitzis
Helen Bell
Julie Murphy
John Weaver
Kellie Hammerstein
Laura Newstead
Lauren Barker
Lawrence Donaldson
Margaret Sinnott
Nicole Richards
Samantha Ross
Terry Lazzarotto

Community Advisory Group

Chloe Millar
Christine Jolly
Florisa Nica
Ian Robinson
John Poletti
John Wise - *Chair*
Maggie Knight
Mary Levaris

Appendix 3 ISEPiCH Forum – Consultation Themes

	THEMES			
	Disparity, equity and access	**Lifelong health and wellbeing**	**Mobility and independence**	**Safety, support and engagement**
CRITICAL ISSUES	• Housing stress, affordability • Food access & security • Socio-economic disadvantage & equity • Access to income, employment & education • Equitable access to early childhood services, support & intervention • Health system service gaps at all levels (ie preventive & well as primary health) particularly with compound conditions • Access to prerequisites for health – housing, food, peace, social justice, income, education	• Focus on social model of health • Serious mental health • Youth self-harm & suicides • Addictions – smoking, alcohol, drugs, gambling • Burden of caring for those with disability, illness, dementia, ageing & chronic conditions • Support for those living with a chronic health issue, multiple chronic conditions & /or complex needs • Need for integration of prevention, health promotion, & chronic health services	• Support for those living with& caring for a long-standing or lifetime disability • Support in situations of acquired or recent onset disability • Support for families with a child or children with a disability • Maintaining independence & mobility as part of healthy ageing • Changing demands on families & services due to increasing rates of dementia	• Social inclusion & community capacity building • Family & domestic violence • Risk exposure in the community related to o alcohol fuelled behaviour including assault & sexual assault o road trauma o anger & crime • Preventive health behaviours such as o smoking o sun exposure o unsafe sex o home accidents o bullying o alcohol & drug abuse o gambling o vaccinations
CRITICAL POPULATION GROUPS	Closing the GAP, ATSI Health and Wellbeing			Refugees & new arrivals CALD residents
CRITICAL APPROACHES relevant in every theme	Different approaches could be adopted as appropriate for each theme and /or issue: eg prevention, early intervention, health promotion, chronic disease management, service co-ordination, or Consider the continuums from promotion to prevention & end of life choices Consider the continuum from pregnancy/birth, early childhood to ageing & maximising opportunities for quality of life			

Appendix 4 Kingston Bayside PCP Stage One Priorities

1. Promoting Mental Health and Wellbeing - Issues noted include the importance of promoting mental health and wellbeing, of prevention and early intervention, of ensuring equal access to services and that people are aware of what services and supports are available. A number of specific issues and population groups associated with this priority area were identified.

- Suicide
- Social isolation and the need for a socially connected and inclusive community
- Dementia, anxiety and depression
- Alcohol abuse
- Young people
- Older people
- People living with intellectual and other disabilities
- Carers

2. Promoting Physically Active Communities - Issues noted included

- The need to increase the range of affordable and accessible physical activity options
- The role of public infrastructure in supporting physical activity
- The importance of people and agencies knowing what physical activity options and infrastructure are available
- Lack of involvement in physical activity being associated with various other health issues eg diabetes, obsessive on-line activity, poor mental health etc.

3. *Promoting Safe Communities* **-** Two aspects of the promotion of a safer community were noted:

- A safe, healthy and supportive home environment including
    - family violence (adolescent, spousal violence, elder abuse)
    - the factors that can underlie violence in the home eg gambling, alcohol and drug use, unstable mental health
    - physical safety in the home for children, carers and older people
- Safe public environments such as streets, parks, beaches, shopping centres, public transport etc.

4. Promoting Healthy Eating and Food Security **-** This priority was noted as having both nutrition and food security aspects

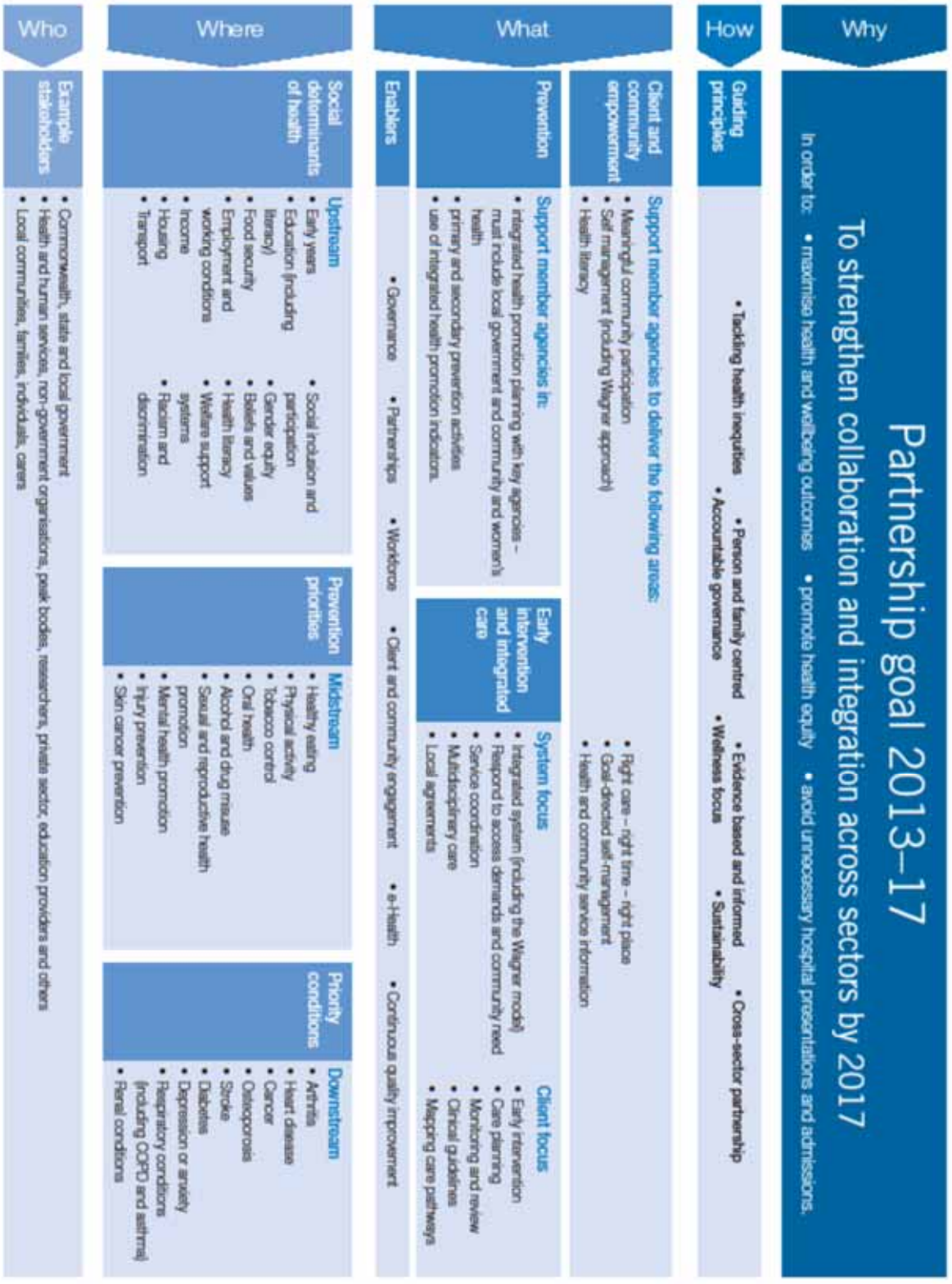
- Poor nutrition, low vegetable intake and poor food choices and associated issues of oral health, diabetes and low rates of breast feeding
- The experience of vulnerable population groups in relation to food insecurity, and the challenges they face in accessing food through emergency relief agencies who themselves are under pressure from increasing demand and are finding it difficult to cope.

Appendix 5 Municipal Public Health & Wellbeing Plan Priorities in the Catchment Area

This table represents a summary of local government priorities as expressed in the draft versions of the 2013-2017 Municipal Public Health and Wellbeing Plans currently being developed or circulated for public comment.

City of Port Phillip *Priorities*	**Glen Eira City Council** *Priorities*	**Stonnington City Council** *Pillars*	**Kingston City Council** *Priority Areas*	**Bayside City Council** *Goals*
1. Social inclusion and connectedness 2. Social and cultural diversity 3. Vibrant and changing communities 4. Responsive and co-ordinated services 5. Sustainability 6. Transport and mobility 7. Access and affordability 8. Housing and homelessness 9. Safety	1. Promote a healthier eating and physically active community 2. Community wellbeing and connectedness 3. Improve mental health 4. Reduce harm from tobacco, alcohol and drugs 5. Public health protection 6. Public health leadership	1. Active and healthy lifestyle 2. Health equity 3. Mental health 4. Safe community 5. Alcohol and tobacco	1. Physical activity and healthy urban environment 2. Socially connected communities 3. Alcohol, tobacco and other drug harm 4. Healthy eating and food security 5. Social influences on health	1. An engaged and supportive community 2. A healthy and active community 3. Safe and sustainable environments

Appendix 6 PCP Program Logic 2013–17



Appendix 7 Australian Social Inclusion Board: Headline and supplementary indicators of social inclusion

MULTIPLE AND ENTRENCHED DISADVANTAGE

Headline indicators

- **Multiple disadvantage:** Proportion of people aged 18 to 64 years experiencing three or more of six disadvantages
- **Entrenched disadvantage:** Proportion of people aged 18 to 64 years experiencing three or more of six disadvantages for two years or more

RESOURCES

Headline indicators

- **Low economic resources and financial stress/ material deprivation:** People in households with low economic resources and high financial stress
- **Persistent low economic resources:** People in households with low economic resources for two or more years
- **People with long-term health conditions affecting their ability to participate in employment:** Number and employment rate of people with disability
- **People with mental illness affecting their ability to participate in employment:** Number and employment rate of people with mental illness (by level of severity)
- **Self-assessed health:** Proportion of population with fair or poor self-assessed health
- **Literacy and numeracy:** Proportion of Year 9 students reaching the national minimum standards for literacy and numeracy
- **Adult literacy/ numeracy:** Proportion of 15 to 75 year olds with at least minimum standard of prose literacy and numeracy
- **Early child development:** Proportion of children in first year of school assessed as "developmentally vulnerable" on two or more domains in Australian Early Development Index
- **Support from family/friends in time of crisis:** Proportion of people able to get support in time of crisis from people living outside household
- **Autonomy—having a voice in the community:** Proportion of people who do not feel able to have a say in the community on issues that are important to them
- **Access to the Internet:** Proportion of people with access to the Internet at home
- **Access to public or private transport:** Proportion of people who have difficulty accessing public or private transport
- **Access to health service providers:** People experiencing difficulties accessing health services
- **Homelessness:** Proportion of the population who are homeless
- **Housing affordability:** Lower income private rental households with housing costs exceeding 30% of household income
- **Feelings of safety:** Proportion of people who feel unsafe alone at home or in their local community at night
- **Children at risk/child protection:** Child protection substantiation rate

Supplementary indicators

- **Low economic resources:** People in households with low income and wealth
- **Financial stress/material deprivation:** Proportion of people in households with high financial stress
- **Real change in income for low income households:** Change in average real equivalised disposable weekly income of low income households
- **Relative income inequality:** Gini coefficient for equivalised household disposable income
- **Life expectancy:** Life expectancy at birth
- **Subjective quality of life:** Proportion of people reporting overall satisfaction with their lives
- **Poor spoken English:** Proportion of people who do not speak English well or at all
- **Non-school qualifications:** Proportion of people aged 25 to 64 years with non-school qualifications
- **Autonomy—having a voice in family:** Proportion of people who do not feel able to have a say in their family on issues that are important to them
- **Access to justice services:** Proportion of people aged 18 and over reporting difficulty accessing justice services

- **Access to service providers:** Proportion of people reporting difficulty accessing services
- **Attitudes to diversity:** Proportion of people reporting positive attitudes towards people from different cultures
- **Housing affordability (supply):** Number of affordable houses available to purchase per 10,000 low income households
- **Repeat homelessness:** Proportion of people experiencing repeat homelessness
- **Family violence:** Proportion of people experiencing family violence in past 12 months
- **Victim of personal crime:** Victims of selected personal crime (including physical assault, threatened assault, robbery, and sexual assault)
- **Victim of household crime:** Victims of selected household crime

PARTICIPATION

Headline indicators

- **Employment rate :**Employment rate (employment to population ratio)
- **Children in jobless families:** Children under 15 years in jobless families
- **Long-term income support recipient:** Long-term recipients of full-rate income support payments
- **Young people not fully engaged in education or work:** Proportion of 15 to 24 year olds that are fully engaged in education and/or work
- **Year 12 or equivalent attainment:** Proportion of people aged 20 to 24 years attaining Year 12 or Certificate II or above
- **Contacted family/friends:** Proportion of people who had contact with family or friends in the past week
- **Participation in community groups:** Proportion of people involved in a community group in the last 12 months
- **Civic engagement:** Participation in civic engagement activities

Supplementary indicators

- **Persistent jobless families with children:** Persons in jobless families with children, where the family has been jobless for 12 months or more
- **Jobless households:** People living in jobless households
- **Long-term unemployment:** Long-term unemployment rate
- **Got together socially with family/friends:** Proportion of people who got together socially with friends or relatives not living with them in the past three months
- **Voluntary work:** Proportion of people who undertook voluntary work in the past 12 months
- **Participation in community events:** Proportion of people who participated in a community event or activity in the past six month

Source: Australian Government. Social Inclusion in Australia: How Australia is faring 2nd edition Social Inclusion Board. 2012 pp 16-19.