



Kingston Bayside Primary Care Partnership

2009 – 2012

Strategic Plan

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Acknowledgements

The development of this Plan is the product of considerable effort and involvement from many individuals and organisations.

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And equally to the Stakeholder and Action Planning workshop participants, our appreciation is extended:

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KBPCP Strategic Plan 2009-12

The Kingston Bayside Primary Care Partnership (KBPCP) is a voluntary alliance which engages over forty government, health and support care providers and community organisations providing services to the Cities of Kingston and Bayside.

Vision & Value Statement

KBPCP is committed to providing leadership in building better health and well being through collaborative coordination and planning for an effective service system.

The Partnership Members are committed to the following key principles:

- collaboration and co-operation;
- sharing of information;
- implementing identified and agreed strategies;
- joint planning;
- recognising the diversity of the service system and the skills and knowledge of participants; and
- an inclusive and culturally sensitive process that involves communication and consultation with agencies, consumers and the community.

The Management Committee has overseen an extensive planning process that commenced in August 2008, with the establishment of the Kingston Bayside Health & Well being Strategic Directions Steering Committee which set as its ambitious goal, the integration of five local health and well being plans.

The planning process also incorporated the Management Committee's own planning workshop where population groups, priority issues and service coordination and health promotion integration approaches were examined.

This was followed by a series of consultations and planning workshops in recent months. This process has distilled the Partnership members' ambitions and expectations and has resulted in the identification of priority areas covering PCP elements of Partnerships, Service Coordination and Integrated Health Promotion. A more detailed description of planning processes may be found under the Service Coordination and Chronic Disease Management and Integrated Health Promotion sections of this document.

This Strategic Plan describes how service providers, communities and governments will work together to plan, coordinate and deliver services to:

- Contribute to the health and well being of all people in our community and help alleviate the burden of disease
- Improve people's experience of and access to primary care services
- Strengthen health promotion and community building
- Reduce preventable hospital admissions by responding to the early signs of disease and to people's need for support

To do this, Kingston Bayside Primary Care Partnership is focusing on the six priority areas for 2009-12:

- 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

National Primary Health Reforms

Having released the draft *National Primary Health Reform Strategy*, together with the *National Health and Hospitals Reform Commission* and the *National Preventative Health Taskforce* recommendations, the Commonwealth Government will be seeking to advance its reform agenda for a strong primary health care system. Health Reform Fact Sheets are available from the Department of Health and Ageing's [yourHealth website](#).

KBPCP will monitor the progress of this initiative and aim to identify opportunities and appropriate responses that will contribute to improving the health and well being of the Kingston Bayside community

Partnerships

Objective

The Partnership will work together to ensure a better connected human services system.

How

Ensure the Partnership remains strong

- Review the existing MOU with the aim of strengthening Partnership arrangements. This review will result in the creation of a Partnering agreement, which formalises member responsibilities and roles in relation to the implementation of this Plan
- All relevant agencies will be encouraged to become partners and contributors to the 2009 -12 Strategic Plan.
- Agency involvement in Strategic Plan activities documented
- Partnership Evaluation will be conducted to assess partnership health and progress.

Create a relevant Strategic Plan that is realistic, supported by a Partnership approach and will have a measurable impact

- An evidence based process will be undertaken by partners to identify strategic priorities that reflect community health and care needs.
- Agreed actions in PCP Strategic Plan are reflected in partner agency strategic plans.

A Strong Partnership

Action	Impact
<ul style="list-style-type: none"> ▪ Review the existing MOU with the aim of strengthening Partnership arrangements. 	<ul style="list-style-type: none"> ➤ This review will result in the creation of a Partnering agreement, which formalises member responsibilities and roles in relation to the implementation of the KBPCP Strategic Plan. ➤ Promotes shared accountability of partner agencies to each other. ➤ Strengthens opportunities for KBPCP Member Agencies to attract external funding
<ul style="list-style-type: none"> ▪ All relevant agencies will be encouraged to become partners and contributors to the 2009 -12 Strategic Plan. 	<ul style="list-style-type: none"> ➤ Improved response to strategic priorities ➤ Increased agency ownership of Plan ➤ Relevant agencies recruited, improves the capacity to successfully achieve expected outcomes
<ul style="list-style-type: none"> ▪ Agency involvement in Strategic Plan activities documented 	<ul style="list-style-type: none"> ➤ Agencies acknowledge each other's commitment, role and contribution ➤ Agency management and staff are better informed and have clearer understanding of the partnership's expectations.
<ul style="list-style-type: none"> ▪ Partnership Evaluation will be conducted to highlight partnership progress and health. 	<ul style="list-style-type: none"> ➤ Adoption of a formal quality improvement approach to measure value of Partnership to its members. ➤ Evaluation will occur at 18 month intervals commencing February 2010

A Relevant Strategic Plan

Action	Impact
<ul style="list-style-type: none"> ▪ An evidence based process will be undertaken by partners to identify strategic priorities that reflect community health and care needs 	<ul style="list-style-type: none"> ➤ The components of this Strategic Plan will incorporate extensive evidence gathering and community and partnership consultation. ➤ Partner agencies engage consumers and community input through workgroups convened to address strategic priorities identified in the Strategic Plan
<ul style="list-style-type: none"> ▪ Agreed actions in PCP Strategic Plan are reflected in partner agency strategic plans. 	<ul style="list-style-type: none"> ➤ Catchment planning reflects and intersects with state, municipal, PCP member agency strategic plans, community and organisational planning. ➤ Addresses the priority of greater integration with Municipal Public Health Planning.

Service Coordination & Chronic Disease Management

Kingston Bayside Primary Care Partnership Service Coordination and Chronic Disease Directions 2009 - 2012

Better Access to Services – Service Coordination

Service coordination aims to place consumers at the centre of service delivery to make sure they have access to the services they need, opportunities for early intervention and health promotion and improved health outcomes. By improving needs identification, assessment and care coordination, the strategy supports consumers to have better access to services and improved health outcomes.

Service Coordination is about implementing common practice, processes, protocols and ways of working between Primary Care Partnership member agencies. Such agreed practice is documented in the Victorian Statewide Service Coordination Practice Manual and its associated resources and the Kingston Bayside Primary Care Partnership supports agencies to implement these practices and achieve the standards outlined in the manual.

Service Coordination expressed as *Better Access to Services* is a strategic priority for the Kingston Bayside Primary Care Partnership¹.

Improving Care for People with Chronic Disease

Integrated Chronic Disease Management is a key component of Victoria's Primary Care Partnership strategy. Integrated Chronic Disease Management is a different way of managing people with chronic illness. Its focus is on keeping people as well as possible rather than responding to illness and it incorporates screening, self management support for clients and multidisciplinary approaches to care.

To facilitate this new way of working, significant shifts in care management and service delivery are required.

The Victorian Integrated Chronic Disease Management Strategy requires Primary Care Partnerships to support such changes by focussing on a common disease groups. Mental Health and Diabetes are among the most prevalent chronic diseases in the Kingston Bayside catchment.

Development of the Kingston Bayside Primary Care Partnership (KBPCP) Service Coordination, Chronic Disease Management Operational Plan

The KBPCP Service Coordination, Chronic Disease Management operational plan has been developed in the context of the overall planning context of the PCP and has involved consultations at management and service provider levels.

¹ More detailed information about Victoria's Service Coordination reform and the Department of Human Services *Better Access to Services: A Policy and Operational Framework* can be found at www.health.vic.gov.au/pcps/publications

At each consultation, participants were asked to consider a range of factors. They included:

- Past Service Coordination/Integrated Chronic Disease Management activities
- DoH requirements for 2009 – 2012
- Kingston Bayside catchment priorities and key population groups identified in the Kingston Bayside Health and Wellbeing Strategic Directions – in particular *Mental Health*
- Key Burden of Disease and Ambulatory Care Sensitive Conditions – *Mental Health and Diabetes*
- Existing and local areas of need/activity for example *Information and Communication* between agencies and the development of *a sub regional Diabetes Model; Access to Services for SRS clients*
- Associated partnership work including *Active Service Framework, Heatwave Strategy* and *HACC/Packaged Care* improvements

They were also asked to indicate their commitment to/ability to participate in various proposed activities. The final plan reflects the outcomes of these discussions and comprises a mix of strategies addressing DoH requirements and local needs.

KBPCP Service Coordination and Chronic Disease Management Action Plan 2009-2010

1. Better Access to Services

Goal 1 To promote consistent practice standards within and across primary and community agencies in Kingston and Bayside		
Objective 1.1	By June 2010, using the Victorian Statewide Practice Manual which addresses all elements of Service Coordination and evidence based Chronic Disease Management practice as a reference, identify common areas of practice improvement needs and formulate action plans to address these areas	
Strategies	Participating Partners	Estimated Impact
Strategy 1.1.1 To support Primary Care and Community agencies in Kingston and Bayside to complete the Statewide Service Coordination and Chronic Disease Management Survey	<ul style="list-style-type: none"> ▪ Access Care Southern ▪ Bayside Council ▪ Bayside General Practice Network ▪ Bentleigh Bayside Community Health ▪ Carer Respite ▪ Central Bayside Community Health Service ▪ Kingston Council ▪ Monash Division of General Practice ▪ Reach Out ▪ Royal District Nursing Service ▪ Sandringham Hospital ▪ Southern Health 	Increased number of agencies completing survey Increase in implementation of the Victorian Service Coordination Manual as identified in the state wide survey
Strategy 1.1.2 To establish a Practice Standards Reference Group for the Kingston and Bayside Partnership with a range of service providers and practitioners actively engaged	<ul style="list-style-type: none"> ▪ Access Care Southern ▪ Bayside Council ▪ Bayside General Practice Network ▪ Bentleigh Bayside Community Health ▪ Carer Respite ▪ Central Bayside Community Health Service ▪ Kingston Council ▪ Monash Division of General Practice ▪ Reach Out ▪ Royal District Nursing Service ▪ Sandringham Hospital ▪ Southern Health 	Increased agency involvement in determining priorities and action for service coordination

<p>Strategy 1.1.3 To develop an action plan based on the above Statewide Survey results for June 2010 – 2012</p>	<ul style="list-style-type: none"> ▪ Access Care Southern ▪ Bayside Council ▪ Bayside General Practice Network ▪ Bentleigh Bayside Community Health ▪ Carer Respite ▪ Central Bayside Community Health Service ▪ Kingston Council ▪ Monash Division of General Practice ▪ Reach Out ▪ Royal District Nursing Service ▪ Sandringham Hospital ▪ Southern Health 	<p>Evidenced based action plan for 2010 – 2012 developed</p>
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<p>Objective 1.2</p>	<p>By June 2010, identify opportunities for increasing the sharing of consumer information using electronic referral</p>	
<p>Strategies</p>	<p>Participating Partners</p>	<p>Estimated Impact</p>
<p>Strategy 1.2.1 To support and resource a Kingston and Bayside e-referral user group</p>	<ul style="list-style-type: none"> ▪ Bayside Council ▪ Bayside General Practice Network ▪ Carer Respite ▪ Kingston Council ▪ Monash Division of General Practice ▪ Sandringham Hospital 	<p>Continued agency involvement in e-referral</p> <p>Vehicle for influencing improvements to e-referral established</p>
<p>Strategy 1.2.2 To encourage new agencies to access Connecting Care e-referral</p>	<ul style="list-style-type: none"> ▪ Bayside Council ▪ Bayside General Practice Network ▪ Carer Respite ▪ Kingston Council ▪ Monash Division of General Practice ▪ Sandringham Hospital ▪ New agencies 	<p>Increase in agencies using e-referral</p> <p>Increase in numbers of e-referral numbers</p>
<p>Strategy 1.2.3 To monitor e-referral traffic through Connecting Care system</p>	<ul style="list-style-type: none"> ▪ Bayside Council ▪ Bayside General Practice Network ▪ Carer Respite ▪ Kingston Council ▪ Monash Division of General Practice ▪ Sandringham Hospital 	<p>Increased awareness of e-referral Traffic via quarterly e-referral report</p> <p>Identification of improvement opportunities</p>

<p>Strategy 1.2.4 To provide e-referral change management and training opportunities</p>	<ul style="list-style-type: none"> ▪ Bayside Council ▪ Bayside General Practice Network ▪ Carer Respite ▪ Kingston Council ▪ Monash division of General Practice ▪ Sandringham Hospital 	<p>Increase in numbers of e-referral users</p> <p>Increase in e-referral numbers</p>
<p>Strategy 1.2.5 To advocate for Interoperability of e-referral systems</p>	<ul style="list-style-type: none"> ▪ Bayside Council ▪ Bayside General Practice Network ▪ Carer Respite ▪ Kingston Council ▪ Monash division of General Practice ▪ Sandringham Hospital 	<p>Acceleration of interoperability opportunities</p>

<p>Objective 1.3</p>	<p>By June 2010, improved communication processes between agencies including General practice facilitated</p>	
<p>Strategies</p>	<p>Participating agencies</p>	<p>Estimated Impact</p>
<p>Strategy 1.3.1 To develop a Practice Standards Reference Group for the Kingston and Bayside Partnership with a range of service providers and practitioners actively engaged</p>	<ul style="list-style-type: none"> ▪ Access Care Southern ▪ Bayside Council ▪ Bayside General Practice Network ▪ Bentleigh Bayside Community Health ▪ Carer Respite ▪ Central Bayside Community Health Service ▪ Kingston Council ▪ Monash Division of General Practice ▪ Reach Out ▪ Royal District Nursing Service ▪ Sandringham Hospital ▪ Southern Health 	<p>Increased agency involvement in determining priorities and action for service coordination</p>
<p>Strategy 1.3.2 To implement agreed approaches for referral and feedback and common practice</p>	<ul style="list-style-type: none"> ▪ Access Care Southern ▪ Bayside Council ▪ Bayside General Practice Network ▪ Bentleigh Bayside Community Health 	<p>A Kingston Bayside PCP referral and feedback protocol developed</p>

	<ul style="list-style-type: none"> ▪ Carer Respite ▪ Central Bayside Community Health Service ▪ Kingston Council ▪ Monash Division of General Practice ▪ Reach Out ▪ Royal District Nursing Service ▪ Sandringham Hospital ▪ Southern Health 	
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Objective 1.4	By December 2010, identify the Kingston Bayside Partnership role in supporting HACC Packaged Care service coordination practice improvements	
Strategies	Participating agencies	Estimated Impact
Strategy 1.4.1 To hold a forum for service providers to discuss support mechanisms	<ul style="list-style-type: none"> ▪ Access Care Southern ▪ Bayside Council ▪ Kingston Council ▪ Carer Respite ▪ Southern Health - ACAS 	Discussion forum held
Strategy 1.4.2 To develop an action plan for 2010 – 2012 based on discussion outcomes	<ul style="list-style-type: none"> ▪ Access Care Southern ▪ Bayside Council ▪ Kingston Council ▪ Carer Respite ▪ Southern Health - ACAS 	Action plan for 2010 – 2012 completed

Better Access to Services

Goal 1 To promote consistent practice standards within and across primary and community agencies in Kingston and Bayside		
Objective 1.5	By December 2010, opportunities for the Kingston Bayside Primary Care Partnership to support local initiatives being implemented in Kingston and Bayside will be identified. Note: this will include Active Service Model, Heatwave and Elder Abuse strategies	
Strategies	Participating agencies	Estimated Impact
Strategy 1.5.1 To hold a forum of service providers to discuss support mechanisms	<ul style="list-style-type: none"> ▪ Access Care Southern ▪ Bayside Council ▪ Bayside General Practice Network ▪ Bentleigh Bayside Community Health ▪ Carer Respite ▪ Central Bayside Community Health Service ▪ Kingston Council ▪ Monash Division of General Practice ▪ Reach Out ▪ Royal District Nursing Service ▪ Sandringham Hospital ▪ Southern Health 	Discussion forum held
Strategy 1.5.2 To develop an action plan for 2010 – 2012 based on discussion outcomes	<ul style="list-style-type: none"> ▪ Access Care Southern ▪ Bayside Council ▪ Bayside General Practice Network ▪ Bentleigh Bayside Community Health ▪ Carer Respite ▪ Central Bayside Community Health Service ▪ Kingston Council ▪ Monash Division of General Practice ▪ Reach Out ▪ Royal District Nursing Service ▪ Sandringham Hospital ▪ Southern Health 	Action plan for 2010 – 2012 completed

Better Access to Services

Goal 2 To connect people to the right services		
Objective 2.1	Increase provider knowledge about services in the Kingston Bayside Catchment	
Strategies	Participating agencies	Estimated Impact
Strategy 2.1.1 Member agencies including General Practitioners maintain up to date information in the Health Service Directory and other relevant directories including Connecting Care	<ul style="list-style-type: none"> ▪ Access Care Southern ▪ Bayside Council ▪ Bayside General Practice Network ▪ Bentleigh Bayside Community Health ▪ Carer Respite ▪ Central Bayside Community Health Service ▪ Kingston Council ▪ Monash Division of General Practice ▪ Reach Out ▪ Royal District Nursing Service ▪ Sandringham Hospital ▪ Southern Health 	Regular maintenance of directory information

Goal 3 To develop and implement agreed service coordination practice for prioritised hard to reach and vulnerable groups		
Objective 3.1	By December 2010, identify service access and coordination improvements for SRS clients in the Kingston Bayside catchment	
Strategies	Participating agencies	Estimated Impact
Strategy 3.1.1 To establish a working group of relevant SRS service providers	<ul style="list-style-type: none"> ▪ HACC Access and Equity ▪ Bentleigh Bayside Community Health ▪ Monash Division of General Practice 	Working Group established
Strategy 3.1.2 To conduct a review of existing SRS services	<ul style="list-style-type: none"> ▪ HACC Access and Equity ▪ Bentleigh Bayside Community Health ▪ Monash Division of General Practice 	Completion of review
Strategy 3.1.3 To develop an action plan for 2010 – 2012 based on discussion outcomes	<ul style="list-style-type: none"> ▪ HACC Access and Equity ▪ Bentleigh Bayside Community Health ▪ Monash Division of General Practice 	Action plan for 2010 – 2012 completed

2. Improving Care for People with Chronic Disease

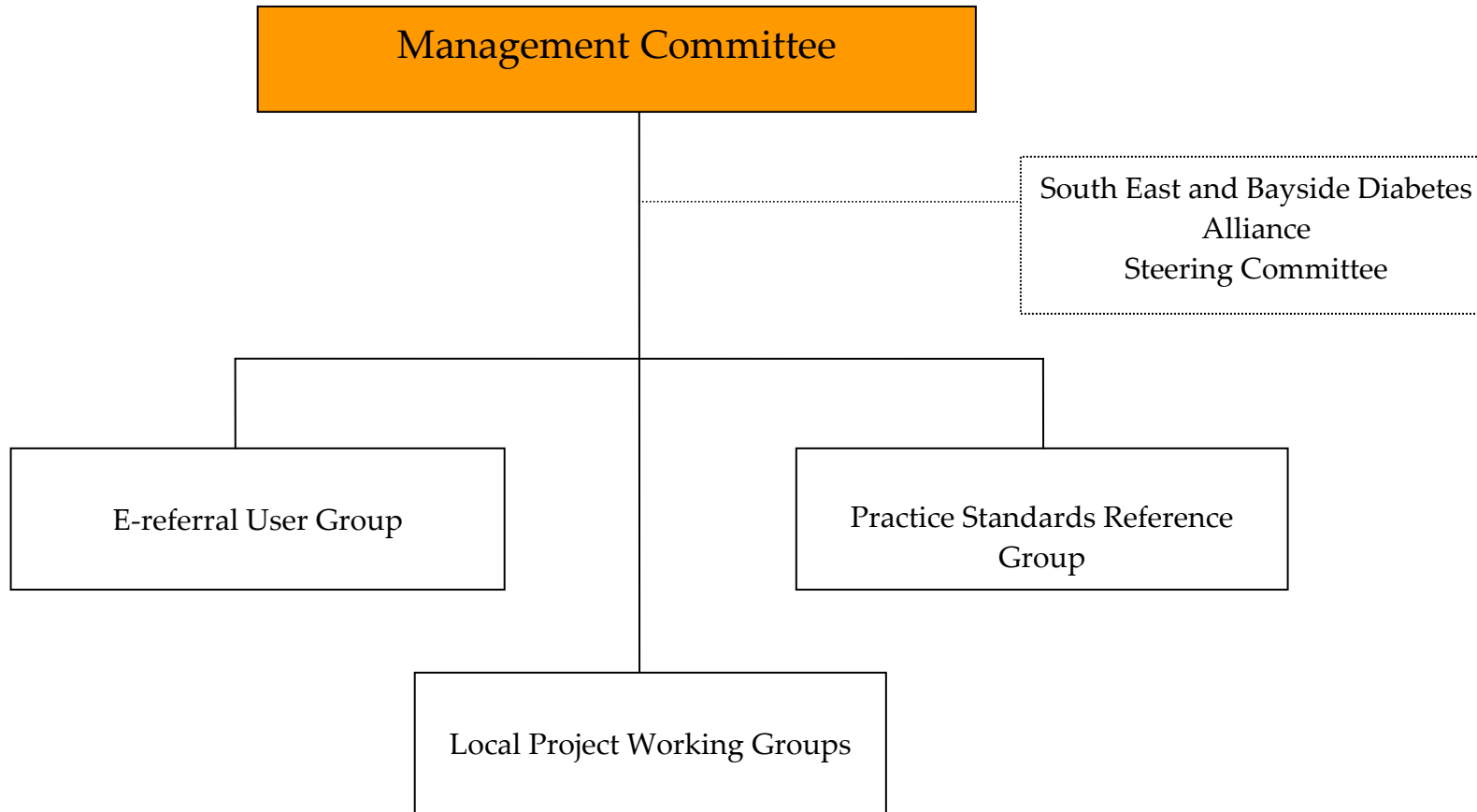
Goal 1 To implement evidenced based practice care models for people with Chronic Disease		
Objective 1.1	By August 2010, identify access and care pathway improvements for people with diabetes through the South East and Bayside Diabetes Alliance	
Strategies	Participating agencies	Estimated Impact
Strategy 1.1.1 Kingston Bayside Primary Care Partnership member agencies partner with South East and Bayside Diabetes Alliance members to develop a coordinated catchment wide model of care	<ul style="list-style-type: none"> ▪ Bentleigh Bayside Community Health ▪ Bayside General Practice Network ▪ Central Bayside Community Health Service ▪ Monash Division of General Practice ▪ RDNS 	Alliance established supported by Kingston Bayside Primary Care Partnership Model of Care Developed
Strategy 1.1.2 Kingston Bayside Primary Care Partnership member agencies participate in mapping of current services and pathways for people with diabetes, the development of improved access and transition to appropriate services	<ul style="list-style-type: none"> ▪ Bentleigh Bayside Community Health ▪ Bayside General Practice Network ▪ Central Bayside Community Health Service ▪ Monash Division of General Practice ▪ RDNS 	Access and Care Pathways identified Information about the range of services is available to providers and consumers
Objective 1.2	By June 2010, determine workforce capacity needs of service providers involved in the care of people experiencing chronic disease	
Strategies	Participating agencies	Estimated Impact
Strategy 1.2.1 To establish a Practice Standards Reference Group for the Kingston and Bayside Partnership with a range of service providers and practitioners actively engaged	<ul style="list-style-type: none"> ▪ Bentleigh Bayside Community Health ▪ Bayside General Practice Network ▪ Central Bayside Community Health Service ▪ Monash Division of General Practice ▪ RDNS 	Practice Standards Reference Group for the Kingston and Bayside Partnership established
Strategy 1.2.2 To develop an action plan for 2010 – 2012 based on discussion outcomes	<ul style="list-style-type: none"> ▪ Bentleigh Bayside Community Health ▪ Bayside General Practice Network ▪ Central Bayside Community Health Service ▪ Monash Division of General Practice ▪ RDNS 	Action plan for 2010 – 2012 completed

2. Improving Care for People with Chronic Disease

Goal 1 To implement evidenced based practice care models for people with Chronic Disease		
Objective 1.3	To continue to develop partnerships with Divisions of General Practice to improve care coordination for people with diabetes and other chronic diseases	
Strategies	Participating agencies	Estimated Impact
Strategy 1.3.1 Until June 2010, participate in the Bayside General Practice Network ABHI initiative to improve care coordination and early intervention strategies for people with diabetes	<ul style="list-style-type: none"> ▪ Central Bayside Community Health Service ▪ Bayside General Practice Network 	Development of referral and feedback protocols and further implement the Victorian Statewide Service Coordination Practice Manual
Strategy 1.3.2 To identify the Kingston Bayside Primary Care Partnership role in sustaining outcomes of the ABHI initiative post June 2010	<ul style="list-style-type: none"> ▪ Access Care Southern ▪ Bayside Council ▪ Bayside General Practice Network ▪ Bentleigh Bayside Community Health ▪ Carer Respite ▪ Central Bayside Community Health Service ▪ Kingston Council ▪ Monash Division of General Practice ▪ Reach Out ▪ Royal District Nursing Service ▪ Sandringham Hospital ▪ Southern Health 	Role and sustainability options identified Outcomes of ABHI initiative incorporated into routine practice

Kingston Bayside Service Coordination and Integrated Chronic Disease Management Structure

2009-2010



Integrated Health Promotion

Kingston Bayside Health and Wellbeing Strategic Directions 2009 - 2013

1. Introduction

As part of their commitment to an integrated approach to health and wellbeing, the Kingston Bayside Primary Care Partnership, Kingston City Council, Bayside City Council, Central Bayside Community Health Services and Bentleigh Bayside Community Health share a common vision in relation to the potential of working together towards common priorities:

'The partnership is committed to planning and working collaboratively on identified health and wellbeing priorities to improve the health outcomes of the Kingston Bayside community'

2. Background

Local Government, Community Health and the Primary Care Partnership are required by legislative or funding agreements to develop strategic public health / integrated health promotion plans for their communities.

A unique opportunity emerged, that post June 2009 the planning cycles aligned for the first time for each of these five local Kingston Bayside health and wellbeing plans. This presented an exciting opportunity to undertake a truly collaborative planning process, to ensure common health and wellbeing priorities and effective integrated health promotion activity across the catchment.

The focus on integration supports key stakeholders and local agencies to have greater capacity to address key health and wellbeing priorities effectively, and to minimise duplicated, fragmented effort.

3. Policy context

The Kingston Bayside Health and Wellbeing Strategic Directions have been developed within the context of national and state priorities and are guided by a strong commitment to working within a social model of health.

4. Our approach

Collaborations: planning with your community was engaged to undertake the consultation process and support the development of a planning framework in partnership with the Project Steering Committee.

The planning process has included:

- The collation and analysis of demographic and population health profile data for each municipality (undertaken by Martin Bonato and Associates Pty. Ltd)
- A telephone survey of 402 respondents across the municipalities of Kingston and Bayside. The survey sample was randomly generated and monitored to reflect the age profile of both municipalities as closely as possible.
- Nine small group discussions with groups identified by the Project Steering Committee. These discussions targeted the views of young people, families, mature adults and older adults from different cultural and socio-economic backgrounds.
- A face-to-face survey with 13 frail aged clients of Home and Community Care services
- Two planning workshops with representatives from local/regional organisations including government agencies, business / corporate, health and community services to consider the consultation and research findings along with their own experience to identify priority health and wellbeing issues for Kingston and Bayside.

In considering the range of health issues identified, the partnership agencies were asked to identify priorities for the strategic directions based on the following criteria:

- Directions are supported by identified needs
- Actions are evidence based
- Actions that would benefit from a partnership approach
- Actions have the potential to achieve measurable outcomes
- There is existing commitment and capacity within the catchment to deliver

6. Strategic Directions

The Kingston Bayside Health and Wellbeing Strategic Directions for 2009 – 2013 have identified the following three health promotion priorities:

- 1. Promoting mental health and wellbeing**
- 2. Promoting accessible and nutritious food**
- 3. Promoting physical activity and active communities**

A number of other important issues were identified through the planning process and need to be considered when addressing the areas above including:

- Chronic disease
- Access and transport
- Housing
- Environment and climate change
- Economic environment

The following neighbourhoods have been identified as priority areas for action:

- Clayton South / Clarinda
- Chelsea / Bonbeach
- Highett / Hampton East

The following population groups of particular significance have been identified:

- Children and Families
- Young people aged 12-25 years
- Older adults
- CALD
- Homeless
- People with a disability and their carers

Where to from here

It is anticipated that these strategic directions will inform the development of individual agency plans to facilitate coordinated and integrated health planning and avoid duplication to maximise the outcomes of health promotion investment in Kingston and Bayside.

The full Kingston Bayside Health and Wellbeing Strategic Directions Paper 2009-2013 is available at www.kingstonbaysidepcp.org.au



KBPCP Integrated Health Promotion Action Plan 2009-2010

1. Promoting Mental Health and Wellbeing

Goal: To strengthen community connectedness and social inclusion in Kingston and Bayside				
Objective 1	By June 2010, identify two priority evidence based Mental Health Promotion initiatives to increase community connectedness and social inclusion in Kingston and Bayside			
Partner Agencies	Strategies	Performance measures	Data collection methods	IHP impact reporting measure
<ul style="list-style-type: none"> ▪ Central Bayside Community Health Services ▪ Bentleigh Bayside Community Health ▪ Kingston City Council ▪ Bayside City Council ▪ Reach Out Mental Health ▪ AccessCare Southern ▪ New Hope Foundation ▪ Gamblers Help Southern ▪ Inner South Community Health Service ▪ Bayside GP Network ▪ Royal District Nursing Service ▪ Middle South Primary Mental Health Team ▪ Women's Health in South East ▪ Southern Health ▪ Monash Division of General Practice 	1.1 To establish a Mental Health Promotion partnership for Kingston and Bayside with a range of sectors and disciplines	Partnership established % of KBPCP member agencies engaged in the Mental Health Promotion Partnership % of Mental Health Promotion partners with Mental Health identified as a priority in organisational plans	VicHealth Partnership Analysis Tool Minutes Partnering Agreements Action Planning Session Notes	Partnerships Reach Organisational Development
	1.2 To develop an evidence based action plan for July 2010 – July 2013 with a focus on priorities and directions identified through the Kingston Bayside Strategic Health & Wellbeing Planning process 2009	Evidence used to inform priorities Community members involved in health promotion planning Integration of health promotion planning process Mental Health Promotion Action plan is developed with at least 2 priorities identified	Kingston City Council Health Profile Feb 2009 Bayside City Council Health Profile Feb 2009 Kingston Bayside Health and Wellbeing Planning Consultation and Research Summary May 2009 Action plan	Organisational Development Reach: Community Participation Organisational Development Partnerships
	1.3 To resource the implementation of the evidence based action plan for 2010 – 2013	Action plan resourced	KBPCP Partnering Agreements	Partnerships
	1.4 To identify capacity building needs for Kingston and Bayside	Capacity building needs identified	DH SMR Health Promotion and Needs Assessment Survey	Resources
				Workforce Development

Promoting Mental Health and Wellbeing

Goal: To strengthen community connectedness and social inclusion in Kingston and Bayside				
Objective 2	By June 2010, pilot one evidence based model to raise awareness of problem gambling as a public health issue in a CALD community			
Partner Agencies	Strategies	Performance measures	Data collection methods	IHP impact reporting measure
<ul style="list-style-type: none"> ▪ Gamblers Help Southern ▪ Central Bayside Community Health Services ▪ New Hope Foundation ▪ Kingston City Council ▪ Bentleigh Bayside Community Health 	2.1 To establish a Problem Gambling Partnership in Kingston and Bayside	Partnership established % of KBPCP member agencies actively engaged in the Problem Gambling partnership	VicHealth Partnership Analysis Tool Minutes Partnering Agreements	Partnerships Organisational Development
	2.2 To identify priority CALD communities and one evidence based model for raising awareness of problem gambling as a public health issue in the community	Priority CALD communities identified One evidence based model identified Community Members involved in health promotion planning	Minutes 2007 Vietnamese Women's Program Report 2008 Cambodian Women's Program Report Consultation with Clayton South Mother's Club Survey at Mental Health and Wellbeing Forum Oct 2009	Partnerships Reach: Community participation
	2.3 To pilot one evidence based approach to raise awareness of problem gambling as a public health issue, including knowledge of risk and protective factors	Number of participants Number of sessions Increased awareness of problem gambling	Attendance register Pre and post survey of program participants	Reach Personal skills: Increased knowledge

2. Promoting Physical Activity and Active Communities

Goal: To enhance access and opportunities to increase physical activity in Kingston and Bayside				
Objective 1	By June 2010, establish a partnership with a range of local, government, non-government and private sector agencies to deliver evidence based falls prevention programs to older adults aged 65+ in Kingston and Bayside			
Partnering Agencies	Strategies	Performance measures	Data collection methods	IHP impact reporting measure
<ul style="list-style-type: none"> ▪ Bentleigh Bayside Community Health ▪ Inner South Community Health Service ▪ Alfred Health – Caulfield Community Health Service ▪ New Hope Foundation ▪ Stonnington City Council ▪ Port Phillip City Council ▪ Glen Eira City Council ▪ Kingston City Council ▪ Bayside City Council ▪ Russian Ethnic Representative Council ▪ Central Bayside Community Health Services ▪ Southern Health ▪ Royal District Nursing Service 	1.1 To establish an ongoing Falls Prevention partnership with agencies who deliver services to older people	Partnership established % of KBPCP member agencies actively engaged in the Problem Gambling partnership	VicHealth Partnership Analysis Tool Minutes	Partnerships Reach
	1.2 To engage appropriately skilled staff to select Home and Community Care eligible clients and deliver evidence based multi strategy falls prevention programs	Staff recruited Group and home based programs delivered Number of participants Number of sessions Clients satisfied	Program documentation Attendance records Client satisfaction surveys	Leadership Reach
	1.3 To support evidence based group programs for Home and Community Care eligible clients aged 65+ years assessed as being at risk of falls	% of eligible clients participating in group programs % of eligible clients with low health status Increased knowledge and awareness of how to reduce risk of falls Changes in behaviour Reduction in falls	Program documentation including summary of eligibility assessments Health care card holder, pension, public housing Pre and post client survey Client Survey Pre and post strength and balance measurements Client falls report	Reach Personal skills: Increased knowledge Healthy lifestyles: Changes in health related behaviours

Promoting Physical Activity and Active Communities

Goal: To enhance access and opportunities to increase physical activity in Kingston and Bayside				
Objective 2	By June 2010, the Kingston Bayside Primary Care Partnership will seek to obtain ongoing strategic commitment from Being Active Eating Well partner agencies to increase physical activity among 0-12 year olds in Kingston and Bayside			
Partner Agencies	Strategies	Performance measures	Data collection methods	IHP impact reporting measure
<ul style="list-style-type: none"> ▪ Kingston City Council ▪ Bayside City Council ▪ Central Bayside Community Health Services ▪ Bentleigh Bayside Community Health ▪ New Hope Foundation ▪ Adult Multicultural Education Service ▪ Family Life ▪ Kinect 	2.1 To continue to support the implementation of the Being Active Eating Well Community Demonstration project until completion in June 2010	<p>All project initiatives completed</p> <p>Consultant engaged to support local evaluation process</p> <p>Final KBPCP Being Active Eating Well Evaluation Report produced</p>	<p>Surveys</p> <p>Focus groups</p> <p>Stakeholder interviews</p> <p>Case studies</p> <p>Environment audits</p> <p>Partnership analysis tool</p>	<p>Partnerships</p> <p>Reach, participation & satisfaction</p> <p>Personal skills</p> <p>Healthy lifestyles</p> <p>Supportive environments</p> <p>Healthy public policy</p>
	2.2 To develop an evidence base action plan to increase physical activity among 0-12 year olds for July 2010 – June 2013 with a focus on the sustainability of Being Active Eating Well	<p>Evidence and BAEW evaluation findings used to inform priorities</p> <p>Community members involved in health promotion planning</p> <p>Physical Activity Action Plan developed</p>	<p>Final KBPCP Being Active Eating Well Evaluation Report</p> <p>Kingston Bayside Health and Wellbeing Planning Consultation and Research Summary May 2009</p>	<p>Partnerships</p> <p>Reach: Community participation</p> <p>Organisational Development</p>
	2.3 To resource the implementation of the evidence based action plan for July 2010 – June 2013	<p>Organisational commitment to increase physical activity for 0-12 year olds in Kingston and Bayside</p> <p>Physical Activity Action Plan resourced</p>	<p>BAEW Steering Committee Minutes</p> <p>KBPCP Partnering Agreements</p>	<p>Partnerships</p> <p>Organisational Development</p> <p>Resources</p>
	2.4 To identify capacity building needs for Kingston and Bayside	<p>Capacity building needs identified</p>	<p>DH SMR Health Promotion and Needs Assessment Survey</p>	<p>Workforce Development</p>

3. Promoting Accessible and Nutritious Food

Goal: To increase access and opportunities to improve healthy eating in Kingston and Bayside				
Objective 1	By June 2010, the Kingston Bayside Primary Care Partnership will seek to obtain ongoing strategic commitment from Being Active Eating Well partner agencies to improve healthy eating among 0-12 year olds in Kingston and Bayside			
Partner Agencies	Strategies	Performance measures	Data collection methods	IHP impact reporting measure
<ul style="list-style-type: none"> ▪ Kingston City Council ▪ Bayside City Council ▪ Central Bayside Community Health Services ▪ Bentleigh Bayside Community Health ▪ New Hope Foundation ▪ Adult Multicultural Education Service ▪ Family Life ▪ Kinect 	1.1 To continue to support the implementation of the Being Active Eating Well Community Demonstration project until completion in June 2010	<p>All project initiatives completed</p> <p>Consultant engaged to support local evaluation process</p> <p>Final KBPCP Being Active Eating Well Evaluation Report produced</p>	<p>Surveys</p> <p>Focus groups</p> <p>Stakeholder interviews</p> <p>Case studies</p> <p>Environment audits</p> <p>Partnership analysis tool</p>	<p>Partnerships</p> <p>Reach, participation & satisfaction</p> <p>Personal skills</p> <p>Healthy lifestyles</p> <p>Supportive environments</p> <p>Healthy public policy</p>
	1.2 To develop an evidence base action plan to improve healthy eating among 0-12 year olds for July 2010 – June 2013 with a focus on the sustainability of Being Active Eating Well	<p>Evidence and BAEW evaluation findings used to inform priorities</p> <p>Community members involved in health promotion planning</p> <p>Healthy Eating Action Plan is developed</p>	<p>Final KBPCP Being Active Eating Well Evaluation Report</p> <p>Kingston Bayside Health and Wellbeing Planning Consultation and Research Summary May 2009</p>	<p>Partnerships</p> <p>Reach: Community participation</p> <p>Organisational Development</p>
	1.3 To resource the implementation of the evidence based action plan for July 2010 – June 2013	<p>Organisational commitment to increase physical activity for 0-12 year olds in Kingston and Bayside</p> <p>Healthy Eating Action Plan resourced</p>	<p>BAEW Steering Committee Minutes</p> <p>KBPCP Partnering Agreements</p>	<p>Partnerships</p> <p>Organisational Development</p> <p>Resources</p>
	1.4 To identify capacity building needs for Kingston and Bayside	Capacity building needs identified	DH SMR Health Promotion and Needs Assessment Survey	Workforce Development

Promoting Accessible and Nutritious Food

Goal: To increase access and opportunities to improve healthy eating in Kingston and Bayside				
Objective 2	By June 2010, establish a partnership to deliver a pilot oral health literacy project "Oral Health is Better Health" with adults currently registered on the Community Dental Health Services waiting lists in Kingston and Bayside			
Partner Agencies	Strategies	Performance measures	Data collection methods	IHP impact reporting measure
<ul style="list-style-type: none"> ▪ Central Bayside Community Health Service ▪ Bentleigh Bayside Community Health 	2.1 To establish an Oral Health Promotion partnership including the active engagement of Community Dental Health teams and Dental Health Services Victoria	Partnership established Representatives from Dental Services involved in the planning, implementation and evaluation of the project	Memorandum of understanding. Minutes of meetings Project report	Partnerships
	2.2 Implement and evaluate the pilot "Oral Health is Better Health" project in Kingston and Bayside, promoting the 3 key messages of 'Eat Well, Drink Well and Clean Well' derived from the Oral Health Guidelines for Victorians	Evidence used to inform priorities Community member involved in health promotion planning Health promotion flyer developed with key messages Plan of dissemination developed for health messages Evaluation plan developed including an intervention and control group Participants increased knowledge of 3 key messages Community members participating in the project are from groups in the community identified as having poorest health outcomes	Project brief Kingston Bayside Health & Wellbeing Consultation and Research Summary 2009 Flyer Project brief & final report Evaluation plan Participant questionnaires Participants have health care card.	Organisational development Reach: Community Participation Personal skills: Increase knowledge Personal skills: Increased knowledge Reach

Integrated Health Promotion Structure 2009-2010

