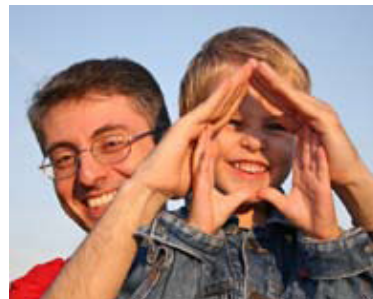




Nillumbik Community Health Service

Integrated Health Promotion Strategic Plan 2009-2012



December 2009

Contact officer: Janine Scott
Senior Manager
917 Main Road, Eltham 3095
Tel. 9430 9100

NCHS STRATEGIC IHP PLAN 2009-2012

CONTENTS

INTRODUCTION	3
BACKGROUND AND CONTEXT	4
NILLUMBIK COMMUNITY HEALTH SERVICE.....	4
THE SHIRE OF NILLUMBIK.....	4
HEALTH PROMOTION	5
IHP PLAN 2009-2012 PRIORITIES & GOALS.....	6
TABLE: PRIORITY HEALTH ISSUES AND GOALS	6
RATIONALE FOR THE GOALS.....	7
EVIDENCE FOR PRIORITY SETTING	9
POLICY AND PRIORITIES - HEALTH PROMOTION.....	9
HEALTH DATA	11
LOCAL RESEARCH AND CONSULTATION	16
VICTORIAN BLACK SATURDAY BUSHFIRE DISASTER.....	19
NCHS STRATEGIC IHP PLAN 2006-09 - REVIEW.....	20
IHP ANNUAL OPERATIONAL PLAN 2009-2010	21
GOAL 1.....	22
GOAL 2.....	32
GOAL 3.....	41
BUDGET SUMMARY - YEAR ONE	49

INTRODUCTION

The Nillumbik Community Health Service (NCHS) Integrated Health Promotion (IHP) Plan for 2009-12 provides strategic direction to our organisation, our partners and the local community related to our health promotion priorities for the next 3 years.

Development of the plan involved a number of activities which included consultations and discussions with NCHS staff, our local partners, and with our local community. In addition, in developing the NCHS Integrated Health Promotion (IHP) plan for 2009-12, we considered:

- Federal, State and Local Government health promotion policies and strategic documents
- NCHS (IHP) Plan 2006-09 implementation plan and evaluation
- NCHS client demographic data (2008-09)
- Relevant Federal, State and Local Area health and wellbeing data
- NCHS Organisational Strategic Plan 2009-11
- Banyule and Nillumbik Primary Care Alliance IHP
- DHS IHP policies
- As well as a number of other sources related to health promotion program/projects which shape and support the implementation of evidence-based initiatives.

Review, discussion and synthesis of these documents and consultation with our local community have led to the formation of three NCHS strategic IHP Priority Health Issues:

- 1. Physical Activity and Nutrition**
- 2. Mental Health and Wellbeing**
- 3. Capacity building.**

This IHP plan provides a short description of health promotion, how the plan fits with our organisation and our community, a summary/ profile of our local community and a summary of relevant data which provides a rationale for our IHP priorities.

The NCHS IHP Annual Operational Plan

For each of the 3 years of the IHP, an annual Operational Plan is developed which articulates specific actions, resources, measures and responsibilities under each Goal. Each Priority Issue is broken down into key Objectives with specific and measurable Strategies which are documented and reviewed on an annual basis.

We are continuing to apply a strategic approach to allocating different and specific portions of time to particular objectives in the plan. We believe this offers employees as well as the organisation more clarity as to how we allocate health promotion hours to particular staff and who is responsible for interventions. All objectives in the plan have an allocated “champion”. This person is NOT responsible for solely undertaking all activities contained in the objective, but is the driver of these strategies and responsible for reporting back to our integrated health promotion working group (HPWG). For most objectives a small, often interdisciplinary team supports the champion.

The annual operational component of the NCHS IHP Plan also attempts to capture and integrate some of the additional health promotion work undertaken across the organisation. In particular it reflects significant input from our Community Development Team and Maternal and Child Health Team.

The NCHS Health Promotion Working Group

Overall responsibility for development, implementation and evaluation of the NCHS IHP and the annual operational plan belongs to the NCHS Health Promotion Working Group. This group has representatives from across the organization and meets monthly to monitor, review and further progress IHP work. A small multi-disciplinary team is allocated to each Objective to implement annually reviewed Strategies (specific actions to achieve that objective). A leader or “Champion” is nominated for each team.

BACKGROUND and CONTEXT

Nillumbik Community Health Service

Nillumbik Community Health Service (NCHS) is a quality, accredited, non profit health service with an independent Board of Directors. Funding comes from a variety of sources including Federal, State and Local Government. The Service works to promote the physical, psychological and social well being of people in the Nillumbik community and surrounding areas.

NCHS provides a range of primary health, community development and health promotion services to the local population. These include:

- Allied health
- Counselling and case management
- Bushfire recovery
- Disability
- Aged care
- Maternal and child health
- Immunisation
- Emergency relief
- Oral health
- Health promotion and community development
- Health education and support group

The NCHS vision is that in partnership with the community we identify and address local health and wellbeing issues. Our core values of collaboration, accountability, accessibility, respect, responsiveness and empowerment drive our organisational and business activities through the operational plan process. The NCHS Strategic Plan 2009-11 focuses on four pillars of:

- Service planning
- Sustainable planning
- Models/practice
- Continuous quality improvement

Each team and service within NCHS is driven by the organizational Strategic Plan.

The Shire of Nillumbik

The Shire of Nillumbik is an interface municipality in the outer North-East of Melbourne, with close knit communities ranging from typical urban settings (Eltham, Diamond Creek and Research) to small rural townships, farms and remote bush communities. The north of the

municipality includes the Kinglake National Park, whilst the south-east edge is bounded by the Yarra River. Nillumbik covers 432 square kilometres and has a population of approximately 62,142 people.

The Nillumbik Community

Nillumbik is made up of a diverse range of people. Of the 62,142 people, 81% were born in Australia. Europe and the Asia-Pacific region are the prominent birthplace regions for overseas born residents. Population growth is relatively stable, with the projections for growth of 3.7% by 2020.

The original inhabitants of the Nillumbik area are the Wurundjeri people. Currently, 0.25% (152) of the population indicated they were indigenous Australians

In terms of age structure, the 35-49 years age group has the greatest percentage (25.9%), whilst the 70-85 age group is the smallest (0.8%). Although Nillumbik has the smallest population in the region, the majority of households are larger than the region, with an average of 3-5 residents per household. 35.8% of the population owned their dwelling, 50.4% were purchasing and 9.3% were renting.

Sixty-two percent of Nillumbik families were couple families with children and 11% are one parent families.

The majority (61.4%) of the population have a religious affiliation, with Catholic being the dominant type of religion. The average weekly income is relatively higher in Nillumbik than many other LGA's in Victoria.

Health care and social assistance is the dominant industry people of Nillumbik work in, closely followed by retail and construction. The major occupation categories are professional (24%), clerical and administration, and technicians and trade workers.

The size of Nillumbik Shire's labour force in 2006 was 32,729 persons; of which 11,790 were employed part-time (36.0%) and 19,072 were full time workers (58.3%). Overall, 96.9% of the potential labour force was employed with 69.4 % employed out side the Nillumbik Shire.

The method of travel to work of the residents in Nillumbik Shire in 2006 shows that 7.1% used public transport, while 72.0% used a private vehicle.

There are over 20 primary schools and 7 secondary schools within the Shire of Nillumbik.

Health Promotion

NCHS understands **health promotion** as the process of enabling people to increase control over, and to improve their health (Ottawa Charter, 1986).

In Victoria, the term **integrated health promotion** refers to agencies and organisations from a wide range of sectors and communities in a catchment (local area) working in collaboration using a mix of health promotion interventions and capacity building strategies to address priority health and wellbeing issues. ([IHP Resource Kit, DHS, 2003; 3](#))

Our Partners in Health Promotion

NCHS continues to build upon the strong networks and partnerships both at a local and regional level. These relationships help ensure that our health promotion initiatives are not isolated but draw on the collective strengths of a number of organizations.

Major partners in our health promotion include:

- Shire of Nillumbik
- Banyule and Nillumbik Primary Care Alliance
- North East Valley of General Practice'
- YMCA Eltham and Diamond Creek
- Banyule/Nillumbik School Focused Youth Service
- Berry Street Victoria
- Department of Health- North West Region
- Women's Health in the North
- Nillumbik Living and Learning Centres

Major networks which relate to the NCHS IHP include:

- Banyule and Nillumbik Youth Providers Network
- Nillumbik Family Violence Network
- North-West Region Health Promotion Network
- Banyule and Nillumbik Primary Care Alliance IHP planning group
- Community Participation in Community Health
- Nillumbik Best Start Partnership

The NCHS Strategic Plan (2009-11) emphasises the *“embedding of a population based approach to our integrated health promotion plan with an emphasis to work in partnership with the Shire Council to build healthy communities”*.

IHP PLAN 2009-2012 PRIORITIES & GOALS

NCHS has adopted a strategic approach to health promotion by focusing our HP activities on a limited number of key health priorities. This approach is intended to make the best use of our skills and resources, avoid duplication with other services providers. Analysis of the above literature and knowledge of the Nillumbik community has therefore led to the adoption of the following IHP Priorities for 2009-12. The following strategic Goals were developed from these priorities.

TABLE: Priority Health Issues and Goals

PRIORITY ISSUES	GOALS
Physical activity and Nutrition	1. Reduce the incidence and severity of chronic disease in the community by increasing healthy eating and participation in physical activity.
Mental health and Wellbeing	2. Improve mental health and wellbeing in the community by increasing access, support, engagement and social connectedness.
Capacity building	3. Ensure that NCHS delivers quality, evidence based health promotion programs, activities and services.

Rationale for the Goals

Goal Area 1

This goal area targets chronic disease and obesity. **Physical Activity** and **Nutrition** are grouped together in one goal area because health promotion interventions (or actions 'on the ground') often overlap or are common to both. Specific objectives in the plan are directed towards at-risk target groups including older people, young children and their families, bushfire affected communities as well as the broader community.

At different life stages, risk factors for chronic diseases and their determinants include genetic predisposition; poor diet and lack of exercise; alcohol misuse and tobacco smoking; stress, violence and traumatic experiences; and inadequate living environments that fail to promote healthy lifestyles. With this Goal, NCHS continues its successful work on the prevention of chronic disease by focusing on poor diet and lack of exercise.

Fruit and vegetable consumption is strongly linked to the prevention of chronic disease. In Australia, 46% of Australian adults eat less than two serves of fruit per day and 86% eat less than five serves of vegetables per day. Of the overall health burden, 2.7% can be attributed to inadequate fruit and vegetable consumption in men and 1.5% can be attributed to inadequate fruit and vegetable consumption in women.

Excess body fat increases the risk of developing a range of chronic conditions, including Type 2 diabetes, cardiovascular disease, high blood pressure, certain cancers, osteoarthritis, and psychological disorders. In Australia, 62% of men and 45% of women are overweight or obese. High body mass contributed 7.5% to the overall health burden in Australia, with Type 2 diabetes (40%) and ischaemic heart disease (34%) the major risks. Currently in Australia the potential opportunity cost savings to the health sector are \$812 million, if we were able to eliminate obesity and overweight from the population.

Physical inactivity is linked to an increased risk of ill health or death, particularly relating to cardiovascular disease. Regular physical activity reduces cardiovascular risk directly and indirectly, by decreasing blood pressure and overweight. It also improves the levels of HDL ("good" cholesterol) and strengthens the musculoskeletal system, and reduces stress, anxiety and depression. Physical activity incorporates not only specific exercise or sport, but also incidental activity (such as housework) and active transport, such as walking to work. In Australia, 67% of men and 74% of women are either sedentary or have a low level of exercise. Physical inactivity contributed 6.6% of the overall DALY health burden in Australia, with ischaemic heart disease (51%) the major risk. The potential cost savings to the health sector In Australia are \$672 million if the prevalence of physical inactivity was eliminated.

(Ref: The health and economic benefits of reducing disease risk factors - Research Report, AIHW 2008 - Australia's Health 2008)

Goal Area 2

The NCHS approach to **Mental Health and Wellbeing**: is based on the VicHealth 'Mental Health Promotion Framework'. This framework supports a population health approach which addresses one or more of the key social and economic determinants of mental health: social inclusion, freedom from discrimination and violence, and access to economic resources.

Data related to mental illness types and prevalence is not widely available at the local government level. In Nillumbik, key issues which impact on mental health and wellbeing have

been identified through a range of local consultations with the community. The most vulnerable or at-risk target groups in Nillumbik with regard to mental health include older people, young people, families with young children (especially for risk of family violence), socially and geographically isolated, and most recently the bushfire affected communities.

Lack of transport is widely recognized as a major risk to health in Nillumbik. Car dependence is high due to a lack of transport alternatives. Locally collected evidence clearly demonstrates that residents who are transport disadvantaged frequently suffer geographic and social isolation. This largely affects those from rural areas who lack a private car or drivers licence, and depend on others for all their transport needs.

Family violence is also an on-going concern in the local community. NCHS has already been a key partner in several collaborative HP interventions to address the issue.

Mental health issues are expected to emerge from the devastating impact of the Black Saturday bushfires in February 2009.

Goal Area 3

Capacity Building continues to be an important health promotion priority for NCHS. Strategies are directed both internally and externally. Internal capacity building strategies focus on building HP planning and evaluation skills within the organization and its own staff. External activities are aimed at strengthening partnerships with the community, consumers and other organisations in the local area, catchment and region. NCHS has also included its work on improving Consumer and Community Participation in this Goal.

A minimum of 10% of resources in this Goal will be allocated to Evaluation, including planning for Evaluation, of HP interventions.

Limiting our actions to three goal areas provides a targeted and effective use of resources.

Flexible Component

In addition, up to 5% of HP resources will be allowed annually as a Flexible Component to enable NCHS to respond to unforeseen local or emerging needs that may arise.

EVIDENCE FOR PRIORITY SETTING

Setting the priorities for the NCHS IHP plan involved a large body of work related to the review of health promotion policy and direction, and evaluation of our IHP priorities for 2006-09. We have also sourced latest health and wellbeing data at a Federal, State and local government level where available.

Policy and Priorities - Health Promotion

National level

The National Preventative Health Strategy was released in September 2009. The Strategy recommends a range of interventions aimed at reducing the chronic disease burden associated with three lifestyle risk factors – **obesity, tobacco and alcohol**.

The strategy focuses on:

- **Shared responsibility – developing strategic partnerships** – at all levels of government, industry, business, unions, the non-government sector, research institutions and communities
- **Act early and throughout life** – working with individuals, families and communities
- **Engage communities** – act and engage with people where they live, work and play; at home, in schools, workplaces and the community. Inform, enable and support people to make healthy choices
- **Influence markets and develop coherent policies** – for example, through taxation, responsive regulation, and through coherent and connected policies
- **Reduce inequity** through targeting disadvantage – especially low socioeconomic status (SES) population groups
- **Indigenous Australians** – contribute to ‘Close the Gap’
- **Refocus primary healthcare towards prevention.**

The challenge for our work at NCHS is to ensure that our health promotion priorities align, as best as practicable, with the National Agenda. Our priority area of physical activity and nutrition will pick up on the priority actions from the Strategy. In addition, in the next 3 years, with more funding and the commencement of a National preventative health body, NCHS will further position itself to respond to the new national agenda.

State level

The overarching aim of the health promotion priorities in Victoria is to improve overall health and reduce health inequalities.

The community health sector in Victoria has been informed by the IHP Framework (resource kit) since 2003 in its approach to health promotion. The IHP Framework is built on the social

model of health and social determinants. In considering how best to achieve effective integrated health promotion, organisations must ensure that it has in place:

- Effective partnerships
- A mix of interventions and common planning framework
- A broad range of sectors contributing to the initiatives

(DHS, IHP Resource Kit p3)

State government funded health promotion work is focused on one or more of the following seven health promotion priorities:

- Promoting physical activity and active communities
- Promoting accessible and nutritious food
- Promoting mental health and wellbeing
- Reducing tobacco-related harm
- Reducing and minimising harm from alcohol and other drugs
- Safe environments to prevent unintentional injury
- Sexual and reproductive health.

(Developing a new framework for promoting health and wellbeing in Victoria - A discussion paper. DHS 2008 p3)

The NCHS IHP addresses the Victorian Government priorities of promoting physical activity and active communities, promoting accessible and nutritious food and promoting mental health and wellbeing. The remaining four health promotion priorities are excluded due to the necessary prioritisation of our health promotion work.

VicHealth works in partnership with organisations, communities and individuals to promote good health and prevent ill-health. It also provides communities with resources and strategic priorities

VicHealth's priorities for 2009-2013 are:

- tobacco consumption
- overweight and obesity
- physical inactivity
- social exclusion
- discrimination
- violence
- alcohol misuse
- the links between social and economic disadvantage and poorer health.

NCHS will address the VicHealth priorities of **overweight and obesity, physical inactivity, social exclusion, discrimination and violence** through the 2 priority areas of Physical Activity and Nutrition, and Mental Health and Wellbeing. In addition, VicHealth's mental health promotion framework provides us with a key tool to shape our mental health and wellbeing strategy.

Regional and Local Level

At the regional and local level, health promotion policy and initiatives are largely influenced by the Banyule and Nillumbik Primary Care Alliance (BNPCA) IHP catchment plan and the Shire of Nillumbik Municipal Public Health Plan. Both these plans have expired and preparation for the new plans is underway.

The BNPCA have **Capacity building** as a key feature of future PCP activity and this involves the development of sustainable skills, organisational structures, resources and commitment to health improvement in health and other sectors. The 2006-09 BNPCAIHP catchment plan focused on physical activity, emotional wellbeing and social connectedness. NCHS have developed their 2009-11 IHP in close partnership with the BNPCA and it's member agencies.

The Shire of Nillumbik is in the early stages of it's planning for the 2009-12 Municipal Public Health Plan (MPHP), hence we are not able to draw from this plan. Discussions with the local council indicate that MPHP will target a number of areas with particular focus on **bushfire affected communities** as well as **geographically isolated communities**.

Health data

We have reviewed available data to help inform our priorities. We have also undertaken local research in specific areas to better inform our plans. This document provides only a brief summary of the data we have utilised in informing our IHP.

Although the Shire of Nillumbik often features in media and in research as an LGA of relatively good health status (eg.highest male life expectancy in Victoria), it is still susceptible to the influences of many of the social determinants of health which underpin population health approaches.

Victorian Local Government Areas 2008 Statistical Profile (1.0)

The report compiled by BNPCA for Nillumbik representatives on the IHP Planning Task Group (Primary Source is the **Victorian Local Government Areas 2008 Statistical Profile** (Release 1.0)) demonstrated the many areas in which Nillumbik rates highly in comparison to other LGA's throughout the State. These include:

- High life expectancy,
- High education status and household income,
- low unemployment rates,
- low hospital inpatient separations,
- low disability adjusted life year (DALYs),
- low asthma admission ratio ,
- low diabetes complications admission rate ratio,
- low ratio of drug and alcohol clients,
- low ratio of registered mental health clients.

Nillumbik Health and Wellbeing Profile- Brendan Cairns Consulting

This profile was prepared in June 2009 and provides a range of data which assists in identifying the social, economic and environmental issues impacting on health and wellbeing in Nillumbik.

Population

The age profile of Nillumbik residents at the time of the 2006 Census was younger than the profile for the Melbourne Statistical Division (MSD). The Shire of Nillumbik had a higher proportion of people in the family formation and young family age cohorts ranging from 35 to 49 years and therefore a greater proportion of people aged 0 to 17 years compared to the metropolitan area.

Compared to the MSD, the Shire of Nillumbik had lower proportions of people born overseas. 81% of people usually resident in Nillumbik in 2006 were born in Australia, compared to 64% in the Melbourne Statistical Division. The number of births in the Shire of Nillumbik declined from 770 births in 2003 to 717 births in 2006. The fertility rate for the Shire of Nillumbik—that is, the average number of babies that a woman could expect to give birth to in her lifetime if she experienced current age specific fertility rates, is stable at 1.8, compared to a national rate of 1.8. (DHS Perinatal Data Collection Unit, 2000-2006).

Family and Community

62% of Nillumbik families were couple families with child(ren), and 11% were one-parent families, compared with 48.4% and 15.4% respectively for the Melbourne Statistical Division in 2006.

At the 2006 Census, 11.3% of the Nillumbik population provided unpaid care, compared with 10.0% for the Melbourne Statistical Division. Three out of every four people in Nillumbik who reported providing unpaid care in the two weeks prior to the 2006 census (3,925 in total) were aged between 35 and 64 years.

Census data from 2006 shows that there was a larger proportion of persons who volunteered for an organisation or group in the Shire of Nillumbik than in the Melbourne Statistical Division. Overall, 21.6% of the Nillumbik population reported performing voluntary work, compared with 15.6% for the Melbourne Statistical Division.

Perceptions of Safety were measured in the 2007 Community Indicators Victoria (CIV) Survey. Respondents were asked to rate how safe they felt when walking alone in their local area during the day and at night – Nillumbik respondents report higher levels of feeling safe compared to metropolitan and state-wide averages for both the day and night.

Community Wellbeing Indicators

With the exception of participation in arts and culture, the Shire of Nillumbik has more favourable results across all other indicators in the Community Indicators Victoria Survey (2007) compared to regional and statewide averages. In particular, self reported health, social support, levels of crime, employment rate and household waste recycling all compare highly favourably. Based on these findings, this suggests that community wellbeing outcomes for the Shire of Nillumbik are likely to be near the highest for Victoria.

Social determinants of health

Examination of many of the social determinants of health across the Nillumbik population revealed the following:

Education and Training

Nillumbik has a high level of preschool participation compared to other local government areas in Melbourne. Nillumbik residents have a higher level of tertiary and educational qualifications compared to the metropolitan area with 49% of the population aged 15 years and older obtaining an educational qualification.

Work

In 2001, there were a total of 19,115 persons 15 years and older (59.7% of the labour force) who were employed full time. By 2006, the number of persons employed full time was 19,072 persons (58.3% of the labour force) which is lower than for the metropolitan area.

The number of persons employed on a part time basis increased by 935 between 2001 and 2006, from 10,855 persons to 11,790 persons. The total number of persons unemployed decreased from 1,217 in 2001 to 1,000 persons in 2006 (a decline in the unemployment rate from 3.8% to 3.1%).

Compared to the metropolitan area, a higher proportion of the Nillumbik workforce was employed in health and community services, education, and construction. Other major employment areas for Nillumbik residents include retail trade, manufacturing, property and business services.

Economic Resources

At the 2006 Census, the Shire of Nillumbik had 39% of households in the highest income quartile group (more than \$94,600 per annum) and 13% of households in the lowest income quartile group (less than \$29,000 per annum). Compared to the MSD, Nillumbik had proportionally fewer households in the lowest and medium lowest income quartiles and more households in the highest income group.

In 2006, Nillumbik (Index score of 1104.4) was ranked on the Index of Relative Socio-Economic Disadvantage as the 30th least disadvantaged municipality out of 31 local government areas in metropolitan Melbourne. International and Australian research points to a clear association between socio-economic status, levels of physical activity and healthy eating. People from lower socio-economic groups are less likely to engage in physical activity and tend to eat less nutritious food. This is due to a range of social factors or determinants.

Housing

Between 2001 and 2006, house ownership in Nillumbik declined from 7,963 dwellings to 6,839 dwellings (43% to 36% of all dwellings) whilst house purchases increased from 7,966 to 9,640 dwellings (43% to 50% of all dwellings). Less than 10% of all dwellings in Nillumbik were rental properties compared to nearly 25% in the metropolitan area. Data compiled by Community Indicators Victoria, based on 2006 Census data, indicates that 13.7% of households in Nillumbik were spending 30% or more of gross household income on rent or mortgage payments, compared to 20.2% in the Northern and Western Metropolitan Region and the Victorian State average of 17.7%.

Rental Affordability

In the March quarter 2008, less than 3% of private rental properties in Nillumbik were affordable for either a single or couple with children on the Newstart allowance compared to 25% of private rental properties in Victoria. (Source: Rental Report, March Quarter 2008).

Crime and Justice

The Victorian Department of Human Services notes that intimate partner violence has a greater impact on the health of Victorian women under the age of 45 than any other risk factor. The burden contributed by this form of violence is greater than that for many other risk factors, such as obesity, high cholesterol, high blood pressure and illicit drug use. In 2004/05 and 2005/06, Nillumbik recorded one of the lowest family violence incident rates for the Victoria Police Region 4 based on reported incidents per 100,000 population. In both years, Nillumbik recorded a family violence rate that was approximately 50% lower than for Banyule. (Victoria Police *2005/2006 Provisional Crime Statistics: Family Violence by Local Government Area*).

Communications

Nillumbik had a high level of internet connection compared to the metropolitan area. In 2006, some 77% of all households had an internet connection and 18% of households had no connection. A higher proportion of households in Nillumbik had broadband connection - 55% compared to the MSD 43%.

Transport

At the 2006 Census, more than 90% of all households in Nillumbik owned at least one car compared to 83% for the MSD. 2.3% of households in Nillumbik did not own a car compared to 9.4% in the MSD.

Community Indicators Victoria Survey (2007) asked respondents if their day to day travel had been limited or restricted in the previous 12 months. 17.2% of persons living in Nillumbik had experienced transport limitations in the previous year, compared to 21.0% in the Northern and Western Metropolitan Region and the Victorian State average of 20.3%.

Culture and Leisure

The DVC Indicators of Community Strength report (2006) shows that 42.1% of Nillumbik residents participate in organised sport, which is lower than the metropolitan average of 44.0%.

Participation in Arts and Culture

In the 2007 Community Indicators Victoria Survey, respondents were asked if they had participated in a range of activities in the previous month, including painting, drawing, art and craft, playing musical instruments, singing, writing and performing. 43.6% of persons in Nillumbik had participated in at least one of the selected artistic and cultural activities in the previous month, compared to 46.5% in the Northern and Western Metropolitan Region and the Victorian State average of 46.6%. Participation in arts and Nillumbik Health and Wellbeing Profile June 2009 cultural activities and events helps to foster and build social cohesion and to reduce isolation. These are important contributors to community wellbeing.

Environment

The journey to work data collected as part of the 2006 Census showed there were 2,277 people who caught public transport to work in the Shire of Nillumbik, compared with 21,066 who drove in private vehicles. Determining and understanding the risks to health and wellbeing from climate change for Nillumbik is difficult to determine with little research in this area to date. Direct impacts are likely to include an increase in heat waves, local bushfires, severe storms, floods and landslides. In the advent of more adverse and extreme weather conditions, particularly with an increase in the number of days greater than 35C, the wellbeing of young children and the frail aged may place additional local demands on families, carers and other support services.

There are also likely to be increased stresses on local infrastructure, such as drains, roads and footpaths, higher demand for recreational and aquatic facilities, major challenges in maintaining the quality and standard of reserves, parks and bushland and strains on household and municipal water usage.

Variations within the Shire of Nillumbik

Although much of the above data provides a snapshot of health and wellbeing across Nillumbik, NCHS also focuses on variations within different areas of Nillumbik. As has been noted previously, Nillumbik, as one of seven interface municipalities, features a wide variation in both land use, physical layout and sub-populations (types). Of particular note for our health promotion planning and targeting of particular population groups is:

- In 2006, Hurstbridge and Eltham Central are the areas within Nillumbik with the highest levels of disadvantage. National Health Survey findings indicate that people with lower socioeconomic status are more likely to smoke, exercise less, be overweight and/or obese, and have fewer or no daily serves of fruit. The survey also found that those who were socio economically disadvantaged reported more visits to doctors and hospital outpatient and accident and emergency services, but were less likely to use preventive health services, such as dental services.
- The distribution of the population in Nillumbik suggests that affordable and locational access to community and health services, particularly for rural and northern areas of the municipality, is likely to impact upon health outcomes across the municipality.

- Areas of highest concentration of recent arrivals were in North Warrandyte, Eltham and Diamond Creek.
- Areas of high proportion of one-parent families with dependant children were Eltham, Diamond Creek and Kinglake/St Andrews.
- There were 1,287 residents of Nillumbik who indicated that they needed help or assistance in one or more of the three core activity areas of self-care, mobility and communication. The assistance was required because of a disability (lasting six months or more), a long term health condition (lasting six months or more) or old age. Areas with high proportions were Eltham, Diamond Creek, Hurstbridge and St Andrews
- Residents who do not own or drive a vehicle and live in areas not easily accessible to the main railway line and main bus routes are transport disadvantaged. These areas include Panton Hill, Cottles Bridge, St Andrews, Strathewan, Kangaroo Ground.

Health

In the Community Indicators Victoria Survey (2007), 57.3% of persons living within Nillumbik reported that their health was either excellent or very good compared to 53.8% in the Northern and Western Metropolitan Region and the Victorian State average of 54.3%.

In 2005, life expectancy for a male born in Nillumbik was 81.9 years and 85.4 years for a female. This compared to a Victorian average of 79.8 years for males and 85.4 years for females. (DHS, Life Expectancy by Region, 2006)

At the National, State and Local level, the major categories of the burden of disease are cancer, cardiovascular disease and mental disorders.

Overweight, obesity and smoking are the main contributors to ill health in Australia. Overweight and obesity pose a major risk to long term health by increasing the risk of chronic illnesses such as diabetes, cardiovascular disease and some cancers. In 2005, 54% of men and 42% of women in Victoria self-reported as being overweight.

Research related to body image indicates that between 70-76% of Australian Secondary School female students consistently choose an ideal figure that they wish to have that is thinner than their own. Only 16% of young women are happy with their ideal body weight, whilst Anorexia is the third most common chronic illness for teenage girls in Australia

Nillumbik had the lowest percentage for the prevalence of diabetes in the Northern and Western metropolitan region and ranked 76th for prevalence out of 79 municipalities. In 2006, 1.9% of the population had been diagnosed with diabetes.

Burden of disease data (DHS, 2001) shows the top 10 most prevalent diseases in Nillumbik are:

1. Diabetes mellitus-NIDDM
2. Depression
3. Asthma
4. Osteoarthritis
5. COPD (emphysema and chronic bronchitis)
6. Benign prostatic hypertrophy
7. Ischaemic heart disease

8. Stroke
9. Epilepsy
10. Rheumatoid arthritis

Depression and generalized anxiety disorder are the 2 major mental health issues affecting residents of Nillumbik.

Local Research and Consultation

NCHS has undertaken a number of local based research over the previous 3 years to assist in understanding our community and it's health needs.

Youth Research Project - 2007

During 2007 NCHS consulted **young people in rural Nillumbik**, to:

- Inform planning for future NCHS programs and services to run from the relatively new Hurstbridge (rural) site
- Raise awareness of NCHS services among rural people in Nillumbik
- Provide guidance for other health service providers and community groups in rural Nillumbik.

The youth research project used Action Research methods to engage young people in the investigation, increase their understanding and act for change.

Young people cited their most important health issues as:

- | | |
|--|-----|
| • Lack of transport | 81% |
| • Friends, facilities too far away | 52% |
| • (Lack of) Physical fitness | 47% |
| • Nowhere to hang out locally, lack of activities for young people | 38% |

Additional issues included stress - related to school, family and relationships, concerns with body image and concerns with weight.

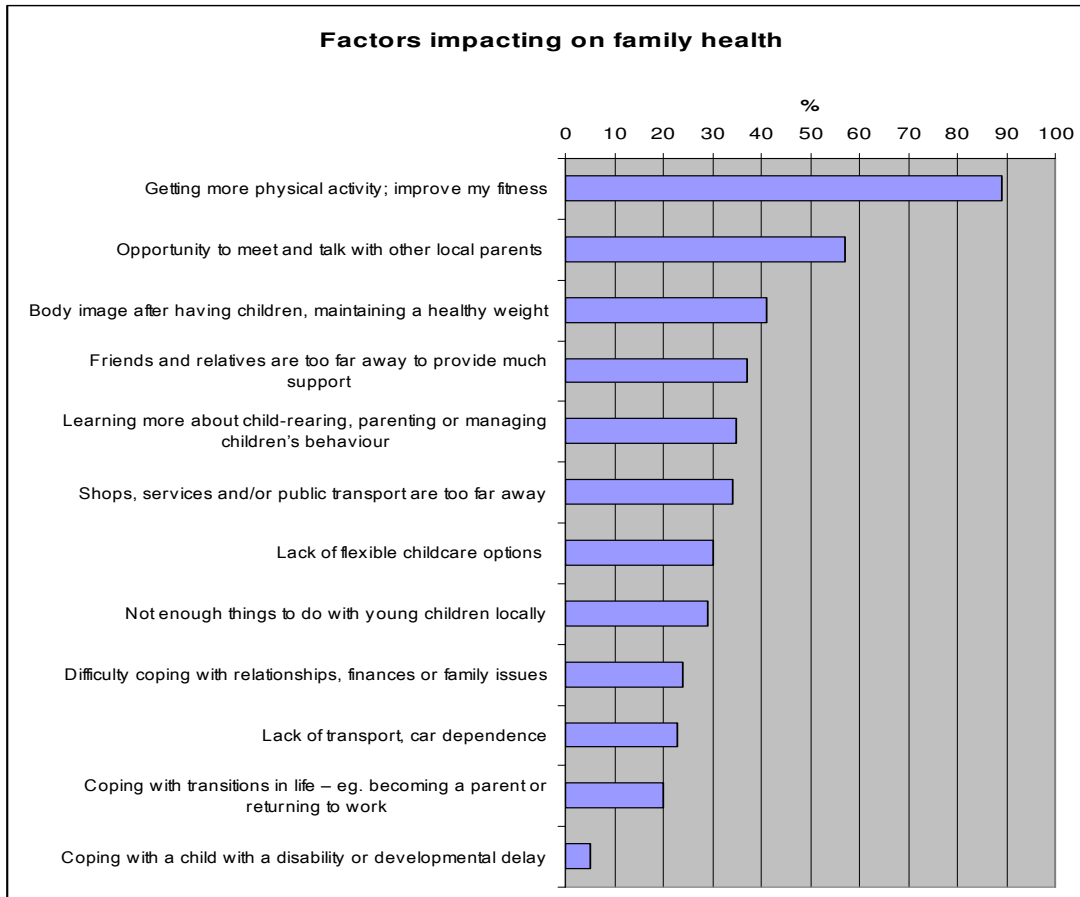
To improve their health, young people said they most needed:

- Increased transport options (with over 50% of respondents)
- Better facilities for undertaking physical activity: bike tracks and walking paths, a fitness centre or gym.
- Youth friendly places to go - public spaces, activities and facilities.
- Improved personal safety: eg. police patrols at night, anti-bullying, less violence.

Rural Families Survey - 2008

In 2008, Nillumbik rural families with young children under 5 were surveyed by mail. 700 surveys were sent out to households with at least one child aged between 6 months and 5yo. Surveys were filled in by the main caregiver. 221 surveys were completed and returned, giving a successful return rate of over 30%.

Major health issues identified by rural families are shown in the following table with percentage of respondents:



Additional health issues for families in rural areas included stress, rural isolation and medical concerns, eg. allergies, chronic dust from unmade roads.

The lack of services was also raised eg. doctors, ambulance, childcare and transport, and a lack of safe footpaths and bike paths for family friendly physical activity.

Youth Homelessness in Banyule and Nillumbik - 2009

NCHS conducted research into the incidence, experience and response to youth homelessness within Banyule and Nillumbik.

Eight government and three non-government schools participated in the survey. Altogether 6,954 students completed the survey. 23 people participated in the focus groups.

The main findings were:

- 98 students were homeless and most were attending a government school (88 per cent);
- Many homeless young people in Banyule and Nillumbik were 'couch surfing' (34) with friends or relatives (i.e. temporarily staying with friends or relatives);
- One in ten students is potentially at risk of homelessness;
- The proportion of students 'most at-risk' of homelessness rises from 1.0 per cent in year 7, peaking in years 10 and 11
- Almost 20 per cent of year 10 students in government schools are at-risk of leaving school
- Approximately 30 per cent of students most at risk of homelessness are highly at-risk of leaving school

The research demonstrated that youth homelessness amongst secondary school students aged 12 – 18 years is a problem in the municipalities of Banyule and Nillumbik.

Nillumbik Health and Wellbeing Profile – Families 2009

(Best Start funded project)

The Nillumbik Health and Wellbeing Profile – Families 2009 project identified and described the factors that place a family (with a child/children aged up to eight years) at risk of experiencing disadvantage, specific to the Shire of Nillumbik (Melbourne, Victoria). The development of the profile was based on a combination of qualitative research, carried out between July and December 2009, and current local level data.

The research has demonstrated that family health and wellbeing has an effect on a child's developmental trajectory, and emotional and social wellbeing into adulthood.

Social connectedness, access to practical and emotional support, psychological health, parenting confidence, income, time and access to services, were found to be risk factors for family wellbeing in the Shire of Nillumbik. Rural families were particularly impacted by reduced access to family services and infrastructure. The most at risk families (single parents or parents with a mental or physical illness, as examples) were further negatively impacted by residing in a community with a wide disparity in income/ social confidence between residents and reduced access to appropriate support services.

In summary, many concerns raised in this and other community consultation require NCHS to partner with, or advocate to, other key stakeholders including:

- Health service providers
- Youth service providers
- Recreation and leisure service providers
- Council - infrastructure, strategic planning
- Education and early years providers
- Community groups, volunteers
- Local business.

Full reports on the following local community consultations are available upon request from NCHS:

- Youth Research Project 2006-2007, October 2007
- Rural Families Survey – Report, January 2008
- Homelessness amongst affluence: Homeless and at risk young people in Banyule and Nillumbik, 2009
- Nillumbik Health and Wellbeing Profile – Families 2009

Victorian Black Saturday Bushfire Disaster

On Saturday 7th February 2009, a series of bushfires devastated a number of regions and communities across Victoria, the scale and intensity of which was unparalleled in this country.

The Shire of Nillumbik was severely impacted by these bushfires with over 40 lives lost, 135 homes destroyed and 180 properties with outbuildings destroyed or damaged across the local areas of Strathewen, St Andrews, Arthurs Creek and Christmas Hills. Approximately 9,800 hectares were burnt, representing 23% of the land area of the Shire. In Strathewen, public assets including the primary school and the community hall were also destroyed.

Since 7 February 2009, NCHS has provided a range of response, relief and recovery measures to bushfire affected families, in conjunction with Council and many other agencies. As the recovery initiatives gather momentum, the NCHS IHP will focus in particular on these communities as evidence indicates that this population group will be at a high risk of developing or exacerbating many health problems. The recently released document *Community recovery after the February 2009 Victorian bushfires: a rapid review* (Dep of Health, 2009) provides the latest summary of the evidence related to the impact of disasters and provides guidance on what works in recovery for these communities.

General consensus on the impact of disasters on health is that the impact is worse:

- When there is widespread death and destruction (as in Victoria, February 2009);
- When there are high levels of personal loss (loved ones, possessions, personal injuries, farm animals, places within which there is social attachment);
- When the physical environment and community systems are so disrupted that households wait long times to be restored, prolonging stress over a long period;
- Among people with lower socio-economic status, migrants and marginalised ethnic groups;
- Among the old and the young, and among women more than men;
- Among people with less effective social support networks (or those whose networks are also compromised by the disaster);
- Among people who lack psychological resiliency and positive psychological traits that have been regularly associated with ability to buffer stressful life events.

In terms of what works in recovery, there are several guiding principals that have emerged from the research into evidence. Essentially these include:

- Recovery should be about betterment, not merely replacement;
- Disasters create new structures of community organisation that could be harnessed for sustained community well-being, rather than being left to taper away;
- Community-led processes (which have been well evaluated in other fields) appear to achieve larger effects and develop more sustainable processes than interventions designed externally that focus simply on individual health behaviours or risks;
- People naturally draw on support in different ways for different reasons and at different levels of intensity according to their own needs, wishes and time frame.

(Community recovery after the February 2009 Victorian bushfires: a rapid review
Dep't of Health, 2009)

The IHP plan will focus on 2 principles for bushfire recovery.

1. Gaining further data and evidence through a range of methods to be better able to target our interventions
2. Focusing our HP work in the priority areas of Physical Activity and Nutrition, and Mental Health and Wellbeing for these communities

NCHS Strategic IHP Plan 2006-09 - Review

In its previous Strategic IHP Plan 2006-2009, NCHS undertook significant work on reorienting health promotion planning and practice across the organisation. The 2009-2012 Plan continues our efforts towards achieving this goal in an on-going process.

As an organisation, one challenge was, and still remains, to ensure that staff are adequately supported and trained to carry out the health promotion activities contained in the IHP Plan. We recognise that these types of activities can take some staff away from their traditional roles as clinicians and require them to develop new skills in HP project management, program planning and evaluation. Capacity building therefore remains a high priority. For the first year, we have allocated a minimum of 10% of HP resources to improved planning and evaluation of strategies, to strengthen our evidence base and embed consumer participation principles and practices throughout our work.

Priority health issues and identified target groups for 2009-2012 remain similar to the previous Strategic IHP Plan, based on evidence of continuing need and to further build on achievements. The devastating impact of the Black Saturday bushfires in February 2009 has prompted a greater inclusion of mental health promotion initiatives - and consideration of bushfire affected communities as a new 'at-risk' target population in Nillumbik across all goal areas of the Plan. In addition, up to 5% of HP resources will be allowed annually as a Flexible Component to enable NCHS to respond to additional unforeseen, local or emerging needs that may arise.



IHP Annual Operational Plan 2009-2010

OVERVIEW OF PRIORITY HEALTH ISSUES AND GOALS

Priority Issues	Goals	Page
Physical Activity and Nutrition	1. Reduce the incidence and severity of chronic disease in the community by increasing healthy eating and participation in physical activity.	22
Mental Health and Wellbeing	2. Improve mental health and well-being in the community by increasing access, support, engagement and social connectedness.	32
Capacity Building	3. Ensure that NCHS delivers quality, evidence based health promotion programs, activities and services.	41
<i>Budget Summary</i>	Anticipated HP Hours and Budget 2009-2010	49

Priority Health Issues: Physical Activity and Nutrition



GOAL 1

Reduce the incidence and severity of chronic disease in the community by increasing healthy eating and participation in physical activity.

Estimated total HP hours for this Goal – 1,000

Objective 1.1	Promote nutrition, healthy eating, participation in physical activity and improved oral health for at risk population groups in Nillumbik.
Population Target Groups	Families with young children 0-8 years. Adolescents aged 12-18 years Adults predisposed to or with an existing chronic disease.
Rationale for Objective	<p>Evidence includes the high incidence of childhood weight issues: 20% of Australian kindergarten children are overweight and 27% of Australian Primary School children are obese. Estimates indicate that if the current increase in childhood obesity is not addressed, 50% of all young Australians could be overweight by 2025. Food habits are established primarily in the first 5 years of life.</p> <p>Evidence for interventions:</p> <p>a) There is abundant literature on the link between the early cessation of breastfeeding and childhood obesity. In Nillumbik, breastfeeding rates drop significantly beyond 6 months despite the benefits of extended breastfeeding. For this reason, we include specific interventions that support mothers to continue breastfeeding for longer.</p> <p>b) The Start Right Eat Right (SRER) Program has been researched at a Statewide level and is evidence based in terms of what works in reducing obesity.</p> <p>c) The Kids Go For Your Life (KGFYL) Program has been researched at a state-wide level and is evidence based in terms of what works in reducing obesity and inactivity. Local responses to the KGFYL Criteria Checklist showed that schools require most assistance with canteens, to implement the nutrition requirements, and Policy development in relation to both nutrition and physical activity</p>
Team and time allocation	MCH, Allied Health
Reporting Measures (see Performance Indicators below)	<ol style="list-style-type: none"> 1. Reach – number of families and children 0-8, adolescents 12-18 years and adults involved in interventions 2. Increased Knowledge – measure of increase in knowledge and awareness related to breastfeeding, oral health, healthy eating and physical activity. 3. Change in health related behaviours – percentage of babies breastfed at 3,6 and 12 months., number of schools implementing a healthy canteen policy, number of SRER accredited child care centres. Participation in community-based physical activity programs for sustainability. 4. Social action and influence – Increase in number of family friendly places and spaces that support breastfeeding.

	5. Reoriented health services – Number of interventions and individuals targeted by interventions that are bushfire affected.
Review date	30 June 2010

Strategies	HP Intervention Type	Performance Indicators:
<p>1.1.1 To sustain or improve breastfeeding rates at key milestone dates of 3 months, 6 months and 12 months:</p> <ul style="list-style-type: none"> • Continue to liaise with the local Australian Breastfeeding Association • Provide and promote MCH centres as breast-feeding friendly facilities • Target all mothers at the 4 month MCH visit to promote breastfeeding beyond 6 months • Conduct a promotional activity during Breastfeeding Week. • Increase number of community places and spaces to support breastfeeding 	<p>Social Marketing and Health Information, Settings and Supportive Environments</p>	<p>Reach – Mothers of children under 12 months</p> <p>Change in Health related behaviours – increase in breastfeeding rates</p> <p>Social Action and Influence- Increase in number of community places and spaces that support breastfeeding</p> <p>Increased knowledge & Reorientation of health services – BF Training for all MCH nurses</p>
<p>1.1.2 Participate in and support appropriate objectives identified as part of NSC's Best Start Action Plan to promote nutrition and physical activity as a priority for children's health:</p> <ul style="list-style-type: none"> • Provide an activity during Children's Week (Oct 2009) for families with children 0-6 years, to promote nutrition and healthy eating • Supporting Family Days program- YMCA • Participation in Playing together, learning together project 	<p>Social Marketing and Health Information, Health education and skill development</p>	<p>Reach – No. of families, teachers, carers and children participating in children's week activity</p> <p>Social Action and Influence – Contribute to evaluation of Best Start activities</p>

<p>1.1.3 Utilise Lady Gowrie funding and Allied Health support for SRER accreditation and re-accreditation of Childcare Centres.</p>	<p>Settings and Supportive Environments, Resources</p>	<p>Reach – No. of childcare centres and families Increased Knowledge – SRER accreditation ensures knowledge and skills to develop a healthy meal menu. Change in Healthy behaviours – No. of children eating healthy meals at childcare Social Action and Influence</p>
<p>1.1.4 Support parents, local communities and Primary Schools to create healthy environments to encourage children to develop healthy nutrition habits for life:</p> <ul style="list-style-type: none"> • Support local primary schools to participate in initiatives that increase PA and healthy nutrition for school children including KGFYL. • Encourage primary schools to utilise the Canteen Advisory Service and develop healthy Canteen Policies • Promote healthy behaviours to primary school children-visits. • Include an “introduction to solids” module in the “new parent’s group” • Deliver appropriate group programs to facilitate healthy eating, such as “Fussy Eaters” and “Just Take a Bite” 	<p>Settings and Supportive Environments</p> <p>Health education and skill development</p>	<p>Reach Number of schools that meet KGFYL accreditation and implement a canteen policy Increased Knowledge Regulatory and Policy environment - Healthy canteen policies implemented Change in health related behaviours – Increase in children eating healthy food; preparation by parents of healthy food options</p>
<p>1.1.5 Promote better oral health through:</p> <ul style="list-style-type: none"> • Increasing awareness of oral hygiene in primary school aged children by writing an article for school newsletters • Promotion of oral hygiene through Maternal & Child Health assessments – “Lift the Lip program” • Increase awareness of damage to teeth caused by oral piercing through secondary school newsletter article • 	<p>Social Marketing and Health Information</p>	<p>Reach – No. of schools, MCH clients Increased knowledge – Increased awareness Reoriented health services – Integrated approach to promoting oral health</p>

<p>1.1.6 Evaluate and disseminate results from the “Help Yourself to Good Health Project”</p> <ul style="list-style-type: none"> • Finalise model and analyse results • Identify opportunities to continue and expand the program to ensure sustainability long term. • Promote program to broader community and health sector • Identify opportunities to implement in other schools including those in bushfire affected communities 	<p>Settings and Supportive Environments</p> <p>Social Marketing and Health Information</p>	<p>Reach – No. participants in evaluation</p> <p>Increased knowledge – Increased levels of knowledge and awareness</p> <p>Change in health related behaviours – Changes in shopping, cooking activities and PA self-reported via follow-up survey/interview in evaluation</p>
<p>1.1.7 Educate and develop skills related to promote healthy lifestyle behaviours including healthy eating and physical activity to young people living in Berry Street’s residential accommodation</p>	<p>Screening, individual risk assessment</p> <p>Health education and skill development</p>	<p>Reach – No. participants</p> <p>Change in health related behaviours – Changes in eating behaviours and participation in physical activity.</p>
<p>1.1.8 Deliver the “Life” program to adults predisposed to diabetes.</p>	<p>Health education and skill development</p>	<p>Reach – no participants</p> <p>Change in health related behaviours – Changes in eating behaviours and participation in physical activity.</p>

Objective 1.2	Facilitate more active and healthy means of getting around by replacing regular short car trips to local destinations such as school, work or shops with active transport such as walking and cycling.
Population Target Groups	Local schools, workplaces and families with young children
Rationale for Objective	<p>Evidence includes rising levels of physical inactivity and childhood obesity in our society. Locally, Nillumbik traffic congestion occurs mainly at school times and is largely due to school-related traffic. Encouraging active transport locally aims to:</p> <ul style="list-style-type: none"> • Improve fitness and health, reduce the risk of obesity, diabetes and heart disease • Increase social and community connectedness by encouraging children and families to become familiar with the local neighbourhood, getting to know other people who live locally. <p>In addition, reducing car use leads to healthier environments and improved health outcomes by:</p> <ul style="list-style-type: none"> • Reducing greenhouse gas emissions and limiting air pollution • Decreasing traffic congestion and improving road safety. <p>Evidence for interventions:</p> <ul style="list-style-type: none"> • This objective will build upon our existing work in this area and use TravelSmart strategies which have been researched at a statewide level and are evidence based in terms of what works in reducing private car use and promoting healthy means of travel to local destinations. • Initiatives such as the Walking School Bus have been demonstrated to increase levels of PA among children who participate, and are popular and successful in Nillumbik.
Team Allocation	Community Development Team
Reporting Measures (see Performance Indicators below)	<ol style="list-style-type: none"> 1. Reach 2. Increased knowledge 3. Change in health related behaviours 4. Social action and influence 5. Reoriented health services
Review date	30 June 2010

Strategies	HP Intervention Type	Performance Indicators:
<p>1.2.1 Continue to promote active transport by supporting the Walking School Bus program:</p> <ul style="list-style-type: none"> • Explore and identify models to support sustainability of the existing successful Nillumbik WSB program • Investigate suitable interventions for schools and children where a WSB is not appropriate through local consultation with primary schools and research into successful models, eg. 'Walk on Wednesdays' program. 	<p>Social marketing, Settings and supportive environments</p>	<p>Reach – No. of participants Change in health related behaviours – Increase in PA Social action and influence – School communities taking responsibility for WSB program and other initiatives Community Capacity – As above</p>
<p>1.2.2. Facilitate NCHS staff to use active transport (eg bike, walk, train) to get to work and attend meetings or local home visits where appropriate:</p> <ul style="list-style-type: none"> • Encouraging NCHS staff to participate in National Ride to Work Day in October 2009. • Advocate for installation of bike racks at NCHS sites 	<p>Health education and skill development</p>	<p>Reach – No. of staff Increased knowledge – as per 1.3.1 Change in health related behaviours – No. of non-car trips utilised to get to meetings, home visits etc</p>
<p>1.2.3 Advocate for improved infrastructure, services and initiatives that will increase active transport in Nillumbik, through participation in relevant networks and forums including "Transport Connections" partnership</p>	<p>Community action for social and environmental change Settings and supportive environments</p>	<p>Reach – No. networks participated in Change in health related behaviours – Increase in PA Social action and influence – Community groups supported to advocate for improved transport options and infrastructure in outer regions of Shire Natural and built environment -Improved infrastructure and services</p>

Objective 1.3	Increase and maintain adequate levels of PA with a focus on regular walking , cycling and other forms of PA.
Population Target Groups	At risk population groups: older people (over 50's), people with disabilities, children and young families, people with sedentary lifestyles, staff who are at risk of chronic disease through sedentary work practices in inactive workplaces.
Rationale for Objective	Regular physical activity improves fitness and health, reduces the risk of obesity, diabetes and heart disease. Australian National Physical Activity guidelines recommend a minimum of 30 minutes of moderate exercise each day. Many people spend half their waking hours at work. Workplaces are becoming increasingly sedentary. NCHS aims to increase levels of PA in inactive workplaces in order for sedentary workers to achieve the National target. This Objective builds on a successful pilot program developed at NCHS 2006-09.
Team allocation	Community Development Team, Allied Health., Immunisation team, NCHS staff
Reporting Measures (see Performance Indicators below)	<ol style="list-style-type: none"> 1. Reach 2. Increased knowledge 3. Change in health related behaviours 4. Social action and influence 5. Reoriented health services
Review date	30 June 2010

Strategies	HP Intervention Type	Performance Indicators:
1.3.1 Continue to develop and implement the NCHS workplace based PA policy and program 'Workout at Work' (WAW) for staff who are at risk through sedentary work practices: <ul style="list-style-type: none"> • Thoroughly evaluate the workplace-based PA Policy program at NCHS, including expertise from academia. 	Settings and Supportive Environments Community action for	Reach – NCHS staff and staff from other workplaces Increased knowledge – Staff surveys to measure levels of knowledge

<ul style="list-style-type: none"> Document the Workout at Work project for publication and submission to relevant Awards eg Journal Of HP, Kinect, VicHealth awards, DHS newsletter, to share learnings in the professional arena. Develop a marketing plan to further promote the WAW Workplace Resource Kit with a focus on establishing partnerships both locally and with key peak bodies. Approach government and appropriate peak bodies, eg. VicHealth, Worksafe, Kinect, to assist with further evaluation of the program and costs to support promotion and distribution of the WAW program to other workplaces. Support the implementation of WAW in other sedentary workplaces WAW as requested. 	<p>social and environmental change</p>	<p>Change in health related behaviours – Increased levels of participation in PA</p> <p>Social action and influence – Encourage more active/less sedentary work practices in workplaces, eg walking meetings, PA policy etc</p> <p>Reoriented health services – Change in culture through systems and processes that encourage PA</p>
<p>1.3.2 Participate in collaborative initiatives with Nillumbik Shire Council that promote increased participation in physical activity by the general population, particularly walking and cycling, eg.</p> <ul style="list-style-type: none"> Pram walking groups Hurstbridge Open Space Concept Plan Advisory Group. 	<p>Settings and Supportive Environments</p> <p>Community action for social and environmental change</p>	<p>Reach – No. of participants</p> <p>Change in health related behaviours- Increase in PA</p> <p>Social action and influence /social capital- Improved infrastructure and environment to support participation in PA and social activities</p>
<p>1.3.3 Continue to support on-going collaborative initiatives that promote regular participation in physical activity by at risk population groups including Pryme Time (YMCA-led) for over 50's, Strength Training maintenance programs for those at risk of chronic disease (volunteer-led) and the YMCA's "Open Doors" program to increase access to leisure facilities by economically disadvantaged and bushfire affected families and individuals.</p> <ul style="list-style-type: none"> Promotion of NCHS "You Can" Resource folder to local Gp's highlighting services, and healthy lifestyle related programs. Implement the "Move On" program in collaboration with Eltham YMCA to support increased participation in community based PA. 	<p>Community Action, Settings and Supportive Environments</p>	<p>Reach – No. of participants and GP practices</p> <p>Increased knowledge - Increased knowledge of services and programs by GP's – kits and increased referrals</p> <p>Change in health related behaviours – Increased levels of PA</p> <p>Reoriented health services – Developing partnerships involving leisure services in health promotion interventions</p>

<p>1.3.5 Participate in the Workhealth workplace health check program for NCHS staff</p> <ul style="list-style-type: none"> • Screening made available to NCHS staff • Explore opportunities for NCHS to provide screening services to other workplaces 	<p>Screening, individual risk assessment</p>	<p>Reach –No. of staff participating in screening Increased knowledge – Increased awareness of health risk indicators Action taken to reduce health risks – No. of staff receiving follow-up assessment, treatment Change in health related behaviours – Increased levels of PA and healthy eating Reoriented health services- Focus on supporting staff health and well-being</p>
<p>1.3.6 Investigate current data and evidence on the prevalence of Cancer and Asthma in Nillumbik, including prevention and successful interventions:</p> <ul style="list-style-type: none"> • Establish links with the Asthma Foundation and Cancer Council to identify key issues for people of Nillumbik • Promote Gardasil immunisation to young women in Shire of Nillumbik • Collaborate with NEVDGP to obtain local data related to asthma and management trends in Nillumbik to identify community needs. • Utilise data from the “Beach Report” to identify key health issues for Nillumbik. 	<p>Screening, individual risk assessment and immunisation</p>	<p>Reach- no girls completing Gardasil immunisation Change in Health behaviours – increased immunisation coverage rates Increased knowledge –Increase awareness of cervical cancer prevention</p>

Priority Health Issue: Mental Health and Wellbeing



GOAL 2

Improve mental health and well-being in the community by increasing access, support, engagement and social connectedness.

Estimated total HP hours for this Goal - 1,000

Objective 2.1	Promote initiatives and attitudes that support positive family relationships.
Population Target Groups	<p>Groups at risk:</p> <ol style="list-style-type: none"> 1. Families at risk of relationship breakdown and family violence 2. Men including new dads, sporting clubs and bushfire affected 3. Women and gambling
Rationale for Objective	<p>A VicHealth study in 2004 found that one in five women report being subjected to violence at some time and that it is the leading contributor to death, disability and illness in Victorian women aged 15 – 44. Until now the burden for working towards the end of male violence against women and children has fallen almost entirely on women. Men who care about the women in their lives can also take responsibility to ensure that women live free from violence and its fear, and help to promote positive roles and messages to others in their local community.</p> <p>Bushfire related post traumatic stress is expected to increase in the bushfire affected communities in 2010 and longer term. NCHS service demand for counselling and support services during 2009 already demonstrates family relationships and breakdown as a key issue arising from the bushfires. Evidence from the earlier Canberra bushfires highlights the need to support young people and children long-term following a disaster to prevent disengagement from family, education and employment. <i>Community recovery after the February 2009 Victorian bushfires: a rapid review</i> (Department of Health, 2009)</p> <p>A research project being undertaken by NCHS (as part of the Nillumbik Best Start Partnership) is looking at vulnerable families within the Shire of Nillumbik. The research has identified a number of common issues faced by families within Nillumbik, including lack of parenting confidence. The impact of the 2009 bushfires in the region has also heightened the desire for a safe environment for families to come together to share concerns and access support. Concurrently, there is increasing anecdotal evidence of concerns of parents of teenagers, about their capacity and confidence in parenting skills.</p> <p>In 2006-2007 just over \$446 million was lost in electronic gaming machines in Melbourne's 7 Northern municipalities. Although Nillumbik was the least affected LGA, there is evidence that identified at-risk groups in Nillumbik include young people in relation to internet gambling, the susceptibility of older Victorians linked to the aging population in Nillumbik, and people experiencing mental health issues - which includes bushfire affected communities (<i>Health promotion resource guide for problem gambling prevention in Melbourne's North, BNPCA, June 2009.</i>)</p>

Team allocation	Counselling and Reconnect teams, Maternal and Child Health team, Allied Health team, Community Development team
Reporting Measures (see Performance Indicators below)	<ol style="list-style-type: none"> 1. Reach 2. Increased knowledge 3. Change in health related behaviours 4. Social action and influence 5. Reoriented health services
Review date	30 June 2010

Strategies	HP Intervention Type	Performance Indicators:
2.1.1 Participate in networks and collaborative approaches to decrease family violence, eg: <ul style="list-style-type: none"> • Nillumbik Women’s Network • Banyule-Nillumbik Domestic Violence Network • Family Violence Court Division family violence program at Heidelberg Magistrates Court • Northern Integrated Family Violence Services meetings 	Settings and Supportive Environments, Community action	Reach No of networks, initiatives and participants Social action and influence – collaborative initiatives documented Partnerships – Minutes of network meetings
2.1.2 Service planning - utilise a HP framework <ul style="list-style-type: none"> • Develop and implement policies and procedures which clearly articulate NCHS approaches to management of family violence, elder abuse and related issues. • Review available data and NCHS program/service information to better understand the nature and extent of family violence in Nillumbik and especially among bushfire affected families. • Disseminate and utilise findings from “Vulnerable Families in Nillumbik” Research to NCHS staff, agencies and broader community to inform planning for improved services and strategies to address family violence. 	Settings and supportive environments	Reach – NCHS staff, partner agencies, broader community Increased Knowledge- Dissemination of findings Reoriented Health Services – Integrated models of service delivery identified to address and respond to family and other violence.

<p>2.1.3 Men:</p> <ul style="list-style-type: none"> • Include information especially for dads in new parent groups to educate and support them in their new role. • Raise awareness in the broader community through a White Ribbon Day event. • Support the AFL “Fair Game; Respect Matters” program and activities • Bushfire affected fathers and sons night 	<p>Social Marketing and health information</p>	<p>Reach – No. of participants in initiatives</p> <p>Increased Knowledge – Participant evaluations</p> <p>Social action and influence – Press articles</p>
<p>2.1.4 Develop and implement strategies to build resilience of parents and positive family relationships.</p> <ul style="list-style-type: none"> • Forum to provide information and support to parents of disengaged young people • Deliver a parenting program to increase parenting skills and confidence 	<p>Health Education and Skill Development,</p>	<p>Reach – No. of participants in initiatives</p> <p>Increased Knowledge – Evaluate increase in knowledge of participants</p>
<p>2.1.5 Support the BNPCA “Women and Gambling” project</p>	<p>Settings and supportive environments</p>	<p>Partnerships</p>

Objective 2.2	Raise awareness of mental health among the general population and build resilience in identified target groups to increase emotional well-being.
Population Target Groups	Young people Men Bushfire affected communities
Rationale for Objective	<p>This objective reflects the direction of the new DHS document, “Because Mental Health Matters”, and addresses key determinants of mental health as described in VicHealth’s resource, “Evidence Based Mental Health Promotion”. Our work in this area is being expanded in response to local emerging issues and increasing evidence of need in the community. Strategies that are relevant to our local community reflect the recommended themes for action, target population groups and Action Areas from the Mental Health Promotion Framework 2005-2007 contained in the VicHealth resource.</p> <p>Evidence for the inclusion and direction of youth-oriented interventions is contained in the Youth Participation and Access (YPA) Program 2009-2011 Guidelines. These guidelines highlight the importance of “strengthening young people’s connection to their community and helping them through difficult periods of transition”, with a focus on “vulnerable young people who face extra barriers to participating fully in the life of our communities”.</p>
Team allocation	Counselling and Reconnect team, Allied Health team. Maternal and Child Health team, Community Development team
Reporting Measures (see Performance Indicators below)	<ol style="list-style-type: none"> 1. Reach 2. Increased knowledge 3. Change in health related behaviours 4. Social action and influence 5. Reoriented health services
Review date	30 June 2010

Strategies	HP Intervention Type	Performance Indicators:
<p>2.2.1 Improve the mental health of at risk young people:</p> <ul style="list-style-type: none"> • Deliver a program to address body-image for young people in Nillumbik. • SFYS Secondary School Mental Health consultations for schools with young people affected by the bushfires. • Develop, implement and support appropriate activities to engage young people from bushfire affected communities to promote social connectedness and emotional health and well-being. • Further promotion and distribution of NCHS 'From Harm to Calm' Resource booklets and program • Continue to advocate for inclusion of SSAYP young people in the community • Advocate to government and funding bodies on behalf of Young people at risk of homelessness and for increased accommodation options in Nillumbik. 	<p>Social marketing and Health Information, Settings and Supportive Environments</p>	<p>Reach – No. of young people, through body-image work in a minimum of ten schools across Banyule and Nillumbik.</p> <p>Increased Knowledge – Increased awareness indicated from evaluations and research project. No. of self-harm booklets distributed.</p> <p>Social action and influence - No. of networks participate in.</p>
<p>2.2.2 Participation in relevant Networks and collaboration with local agencies to promote mental health:</p> <ul style="list-style-type: none"> • Support the Hurstbridge Traders Association initiative, "Hear Me" to give children a positive voice in Hurstbridge. • Participate in the development of the Banyule Nillumbik Mental Health and Support Services Guide for Service Providers via the Steering Committee • BN Youth Network • Youth Connections consortium. 	<p>Community action, Social marketing and information, Settings and supportive environments</p>	<p>Reach – Participants including Hurstbridge Primary School community, Hurstbridge Main Street traders.</p> <p>Increased Knowledge – Services Guide distribution.</p> <p>Social action and influence – No. of networks participated in.</p>

<p>2.2.3 Investigate Men’s Health needs and identify appropriate future intervention strategies and target groups, including bushfire affected / at risk:</p> <ul style="list-style-type: none"> • Conduct a forum for men from bushfire affected communities • Explore opportunities to develop a Men’s Shed program. • Support development of men’s parenting skills, eg through involvement in Pit Stop program. 	<p>Health Education and Skill Development, Settings and Environments</p>	<p>Reach – No. of men participating</p> <p>Increased Knowledge – Participant evaluations following parenting initiatives.</p> <p>Change in health related behaviours – Self-reported improved parenting skills from programs.</p>
<p>2.2.4 Raise awareness of mental health and well-being issues among NCHS employees:</p> <ul style="list-style-type: none"> • Raise awareness of the role of PA in improving mental health • Launch of Staff Wellness Kit • Staff Health Day October 2009 • Develop and implement policies and procedures which clearly articulate NCHS approaches to management of workplace bullying and related issues. 	<p>Health Education and Skill Development</p>	<p>Reach – NCHS staff</p> <p>Increased Knowledge – Awareness indicated from evaluation surveys</p> <p>Change in health related behaviours – Increased levels of PA and improved staff mental health self-reported via surveys</p> <p>Reoriented Health Services – Policies implemented to identify and support staff mental health and well-being</p>
<p>2.2.5 Utilise Best Start and NCHS research to support at risk and vulnerable families and promote social connectedness and positive family relationships:</p> <ul style="list-style-type: none"> • enhance existing Child and Family Health Team programs which support family connectedness, including the potential to develop a program for parents of children with additional needs, such as Autism • utilise the research to support future funding applications/program development • Promote the use of the new checklist for family friendly places and spaces, and ensure that NCHS meets the standards for accreditation as a “family friendly” organisation • identifying appropriate supports and opportunities for social connectedness for parents of children with special needs. 	<p>Settings and supportive environments</p>	<p>Reach- No. of funding submissions and programs implemented; no. of families participating in initiatives</p> <p>Reoriented Health Services – NCHS meets family friendly accreditation</p>

Objective 2.3	Increase community participation for residents through local community projects and activities that improve access and foster social connectedness.
Population Target Groups	Transport disadvantaged – youth, rural Older people Bushfire affected
Rationale for Objective	<p>Community connectedness and civic participation are integrally linked with mental health. Local needs studies and community consultations in Nillumbik have consistently highlighted that residents consider social connectedness as a priority for the health and well-being of the community. Community Health has a role in addressing disadvantage at the local level to create a healthier, stronger community.</p> <p>Lack of transport is acknowledged as a major health concern and barrier for many individuals to access essential services and participate in community life. Clear evidence has emerged from local consultations that transport is a very important health issue for some residents of Nillumbik. Nillumbik has very high rates of private car use and car dependence. Some groups of people and some places in Nillumbik experience significant transport disadvantage, ie. rural areas where there is no Public Transport and residents who can't drive or have no licence and car. Transport-disadvantaged groups in Nillumbik include:</p> <ul style="list-style-type: none"> • people with disabilities • young people • older people • families with young children.
Team allocation	Community Development team, Allied Health team, Counselling team
Reporting Measures (see Performance Indicators below)	<ol style="list-style-type: none"> 1. Reach 2. Increased knowledge 3. Change in health related behaviours 4. Social action and influence 5. Reoriented health services
Review date	30 June 2010

Strategies	HP Intervention Type	Performance Indicators:
<p>2.3.1 Advocate for improved public and community transport services to rural and transport disadvantaged people including bushfire affected communities, and support local initiatives that address transport disadvantage in Nillumbik through:</p> <ul style="list-style-type: none"> • TCP Reference Group • NSC MPHP Advisory Committee • Youth Bushfire Support program 	<p>Settings and Supportive Environments, Community action</p>	<p>Social action and influence - Regular participation in committee/steering group meetings and activities Social Capital – Participation by community groups and individuals in community-led activities; Rates of usage for Hurstbridge Community Bus Partnerships – Community Bus management through Araluen disability service.</p>
<p>2.3.2 Respond to local and emerging needs for bushfire recovery of affected communities by working collaboratively with local networks, forums and service providers and in partnership with the local community, including:</p> <ul style="list-style-type: none"> • Nillumbik Bushfire Recovery Social, Health and Well-being group and recovery committees. • Provide support for young people to engage in community rebuilding activities in partnership with NSC, 	<p>Settings and Supportive Environments, Community action</p>	<p>Reach – No. of young people engaged in activities Consumer participation and leadership - Evidence of consumer input, especially young people, in planning and program development processes captured in committee minutes etc. Social action and influence – Evidence of community involvement captured in planning committee minutes etc.</p>
<p>2.3.3 Facilitate improved community participation for families with young children by working in partnership with the Best Start collaboration to deliver three funded projects:</p> <ul style="list-style-type: none"> • Identify family-friendly places and spaces including shops, footpaths, public facilities, parks and open spaces. • Develop a “Family Friendly Places and Spaces” checklist and seek additional funding to implement the checklist. • Conduct a research project into identifying vulnerable families with young children in Nillumbik. 	<p>Settings and Supportive Environments</p>	<p>Projects will be evaluated thoroughly including impact and process evaluation</p>
<p>2.3.4 Reorient service delivery models to improve access:</p> <ul style="list-style-type: none"> • Trial an internet-based paediatric speech pathology service to increase access for rural, working or mobility-disadvantaged clients • Trial a Saturday morning paediatric speech pathology clinic to increase access for working families. 	<p>Settings and Supportive Environments</p>	<p>Reorient health services – Evaluation of trial.</p>

Priority Health Issue: Capacity Building



GOAL 3

Ensure that NCHS delivers quality, evidence based health promotion programs, activities and services.

Estimated total HP hours for this Goal – 1,000

Objective 3.1	NCHS staff will have a sound understanding of Health Promotion theory and practice, including the skills required to effectively plan and deliver HP objectives and strategies.
Population Target Groups	Staff of NCHS
Rationale for Objective	NCHS has an on-going commitment to training all staff in Health Promotion theory and practice with a current focus on evidence-based planning and practice, building in evaluation.
Team allocation	All staff
Reporting measures (see Performance Indicators below)	Organisational Development - Increased organisational commitment to make HP a priority, More effective targeting of HP investment through evidence-based practice, enhanced organisational learning and improved practice through evaluation and dissemination of findings Workforce Development – gaps in HP skills and training identified and addressed
Review date	30 June 2010

Strategies	HP Intervention Type	Performance Indicators:
3.1.1 The IHP Plan's annual Operational Plan for Year 3 (2009-2010) will be presented to all teams within the organisation and discussions held about their role in HP activities.	Organisational Development, Workforce Development	Reach - 80 staff of NCHS

<p>3.1.2 Develop capacity across the organisation to plan, document, promote and evaluate HP work and achievements:</p> <ul style="list-style-type: none"> • Refine the tools and processes for a streamlined organisation-wide approach to HP program planning. • Form small working groups to support implementation of objectives in the IHP Plan. • All staff members to complete a training needs analysis to identify appropriate professional development and training opportunities for staff. • Run Continuing Education sessions to NCHS staff to raise awareness of a range of appropriate evaluation methods, eg. Focus groups, Narrative Evaluation Action Research (NEAR). • Run practice forums to highlight work achieved. • Increase the capacity of NCHS staff to contribute to the evidence base by participating in research activities 	<p>Workforce Development</p>	<p>Reach – No. of staff attending PD sessions Number of practise forums attended by staff.</p> <p>Workforce development -Training needs analysis and skills identification tool developed and all NCHS staff surveyed</p> <p>Organisational development – Policies and Processes to support Hp planning and evaluation developed and documented including clear procedural chart for planning and evaluation</p> <p>Enhanced organisational learning and improved practice - Local research findings disseminated, utilised to inform planning for services and IHP.</p>
<p>3.1.3 All staff in the organisation will be encouraged to undertake HP training:</p> <ul style="list-style-type: none"> • As a minimum, to attend the 4 hour introduction to HP course if they do not have other training in HP. • Relevant staff to participate in the DHS-supported five-day HP training when it is offered. • Support staff to use Qipp’s via internal training and ‘refresher’ sessions. • Provide training and support to individual staff in writing up HP initiatives for internal and external sharing. 	<p>Workforce Development</p>	<p>Reach – No. of staff participating in activities</p> <p>Enhanced organisational learning and improved practice – No of initiatives written up for sharing internally and externally and programs completed on Qipp’s</p>

<p>3.1.4 Review of IHP processes at NCHS</p> <ul style="list-style-type: none"> • Review the purpose and structure of the HPWG TOR to review direction and consider alternative models to support IHP planning, implementation and monitoring of activities. • Investigate the advantages of using QIPPS as a tool to plan and record HP Programs Investigate the advantages of using QIPPS as a tool to plan and record HP Programs Investigate the advantages of using QIPPS as a tool to plan and record HP Programs 	<p>Organisational Development</p>	<p>Enhanced organisational learning and improved practice –Review of IHP processes completed and report written including recommendations.</p>
---	-----------------------------------	---

Objective 3.2	NCHS will actively participate in partnerships and collaborative ventures which facilitate the delivery of quality health promotion work across our catchment.
Population Target Groups	Nillumbik Shire, catchment populations
Rationale for Objective	NCHS has an on-going commitment to Integrated Health Promotion with a focus on population-wide interventions targeting preventable chronic disease. Partnerships with other health service providers and organisations outside the sector are essential to an integrated approach. NCHS also has a commitment to improving evidence-based practice and evaluation of HP projects and activities across the catchment.
Team allocation	MCH, Community Development, Allied Health, Counselling
Reporting Measures (see Performance Indicators below)	Partnerships – percentage of planned IHP initiatives delivered in partnership with local community and other organisations compared to previous year. Organisational development Partnerships
Review date	30 June 2010

Strategies	HP Intervention Type	Performance Indicators:
3.2.1 Continue to participate in BNPCA working parties: <ul style="list-style-type: none"> Steering Group Service Co-ordination Integrated Health Promotion Working Group (IHPWG) collaborative PCP initiatives to enhance health and well-being in Nillumbik. 	Organisational Development Partnerships	Organisational development – Evidence of participation in BNPCA capacity building activities Partnerships -Participation in networks, partnerships and forums as appropriate
3.2.2 Participate in the Municipal Public Health Plan (MPHP) Advisory Committee to Nillumbik Shire Council.	Partnerships	Partnerships – Evidence of participation and collaboration in Municipal Public health Planning

<p>3.2.3 Continue to participate in the DHS N&WMR Health Promotion in Community Health Network including:</p> <ul style="list-style-type: none"> • NCHS will contribute to Regional Health Promotion capacity by supporting the delivery of the four hour Introduction to Health Promotion course across the Northern Region as appropriate. 	<p>Organisational Development</p> <p>Partnerships</p>	<p>Organisational Development – Evidence of participation in Network HP activities</p> <p>Partnerships – Participation in planning and delivery of 4 hour short course</p>
<p>3.2.4 Participate in, and contribute to, appropriate collaborative consultations and forums which facilitate health promotion planning and activities in Nillumbik, including:</p> <ul style="list-style-type: none"> • Nillumbik Community Development Network • Nillumbik Bushfire Community Recovery working groups • Nillumbik Alliance for Children and Families. 	<p>Organisational Development</p> <p>Partnerships</p>	<p>Organisational development – Evidence of participation in capacity building activities</p> <p>Partnerships -Participation in networks, partnerships and forums as appropriate</p>

Objective 3.3	Actively support community and consumer participation in NCHS service planning.
Population Target Groups	Nillumbik community, carers and consumers of NCHS programs and services.
Rationale for Objective	<p>The literature on consumer participation cites many benefits including:</p> <ul style="list-style-type: none"> • Improvements in the quality of health care • Improved health outcomes • More appropriate public policy • Organisations set priorities about areas of improvement that matter to consumers • Increased consumer control over health and health services (Health Issues Centre, 2006) <p>Civic engagement and consumer participation have been shown to have a positive impact on people's health and well being at both an individual and population-based level. It is an effective intervention in increasing social connectedness for disadvantaged and at risk groups. <i>Consulting Young People About their Ideas and Opinions</i> (2004)</p>
Team allocation	All staff
Reporting Measures (see Performance Indicators below)	Consumer participation and leadership Workforce development Organisational development Partnerships
Review date	30 June 2010

Strategies	HP Intervention Type	Performance Indicators:
3.3.1 Support and improve consumer participation in program planning, evaluation and service delivery across the organisation:	Organisational Development	Partnerships - No. of IHP initiatives delivered in partnership with the local community and consumers

<ul style="list-style-type: none"> • Build capacity among staff to utilise community feedback in planning and evaluation of activities • Identify a group of consumers to act in an advisory role in service planning and marketing • Community Development Team to take a leading role in supporting community and consumer participation at NCHS. • Undertake a review of support groups at NCHS, and clarify the role of NCHS staff and consumers, in the ongoing management of these groups 	<p>Workforce Development</p>	<p>Organisational development - Documented involvement of consumers in program development</p> <p>Workforce development - Review and develop 'position descriptions' for staff and consumer roles in support groups</p>
<p>3.3.2 Increase support for, and utilisation of, volunteers at NCHS:</p> <ul style="list-style-type: none"> • Increase the involvement of volunteers in service planning and delivery through development of systems to facilitate their participation in NCHS planning processes. • Build capacity among staff and program areas to involve volunteers in their programs and services. 	<p>Organisational Development</p> <p>Workforce Development</p>	<p>Partnerships - No. of volunteers involved in NCHS activities and programs</p> <p>Workforce development - No. of volunteers involved in NCHS activities and programs</p>
<p>3.3.3 Work collaboratively with NSC and local service providers to consult target population groups in appropriate service and program planning that address:</p> <ul style="list-style-type: none"> • Youth recreation and leisure needs • Aged care, housing and health concerns • Bushfire affected communities especially in Hurstbridge and rural Nillumbik • Families with young children • Other target populations as identified. 	<p>Organisational Development</p> <p>Partnerships</p>	<p>Organisational development - Documented involvement in community consultations</p> <p>Partnerships - Documented involvement in collaborative consultations</p>
<p>3.3.4 NCHS take a leadership role in policy change and advocacy for greater consumer participation by participating in the Statewide Community Participation in Community Health (CP in CH) Network meetings and activities</p>	<p>Organisational Development</p>	<p>Consumer participation and leadership - Documented involvement in Network meetings and activities</p>

Budget Summary - Year One

Funding from DHS = \$257,286

Anticipated HP Hours and Budget 2009-2010

GOALS & HEALTH PRIORITY ISSUES	EST. HOURS	EST. BUDGET
Goal 1 – Priorities: Nutrition & Physical Activity	1,000	81,420
Goal 2 – Priority: Mental Health and Wellbeing	1,000	81,420
Goal 3 – Priority: Capacity Building	1,000	81,420
<i>Flexible component (5%)</i>	<i>160</i>	<i>13,026</i>
Total	3160	\$257,286

Flexible Component

An allowance of up to 5% of HP hours will be allocated in 2009-2010 as a Flexible Component to enable NCHS to respond to any local or unforeseen need that may arise during the 12 months of this operational plan. This represents approximately 150 hours in total.