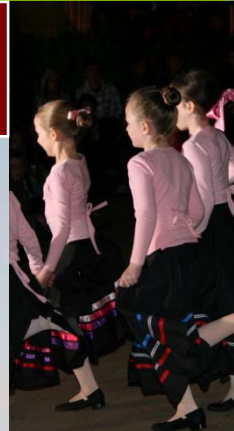


Southern Grampians & Glenelg Primary Care Partnership

Strategic Plan



2009-2012



INTRODUCTION

The Southern Grampians and Glenelg Primary Care Partnership (SGGPCP) is located in the South West of Victoria, 300km west of Melbourne. The catchment for the Partnership is the Southern Grampians and Glenelg Shires. It has a population of 37,700 people.

The SGGPCP is an unincorporated joint venture consisting of agencies which have signed the partnership agreement. Membership is open to any incorporated body that has a commitment to enhancing the health and wellbeing of the community in the Southern Grampians and Glenelg Shires.



We are proud to present the first Strategic Plan for SGGPCP. It builds on the great success and achievement of the past Community Health Plans. On behalf of the Partnership we would like to acknowledge the valuable input of the members and key stakeholders including:

- Aspire
- Balmoral Bush Nursing Centre Inc
- Brophy Family & Youth Services Inc
- Casterton Memorial Hospital
- Coleraine District Health Service
- Community Connections (Vic) Ltd
- Community South West Ltd
- Dartmoor and District Bush Nursing Centre Inc
- Department of Human Services
- Department of Health
- Department of Justice
- Department of Planning and Community Development
- Department of Veteran Affairs
- Dhaurwurd Wurrung Portland & District Elderly Citizen's Association
- Glenelg Shire Council
- Great South Coast Planning Team
- Hamilton Community House Inc
- Heywood Rural Health
- Kyeema Support Services
- Mulleraterong Centre Inc
- National Centre for Farmer Health
- Old Courthouse Community Centre Inc
- Otway Division of General Practice Inc
- Penshurst District Health Service
- Portland District Health
- Portland Neighbourhood House Inc
- RMIT
- Southern Grampians Shire Council
- South West Healthcare – Psychiatric Services
- Western District Health Service
- Winda Mara Aboriginal Corporation

We also acknowledge and thank Fi Mercer of FMC for her contribution, guidance and facilitation in the development of this Plan.

Kevin O'Brien
Chair

Janette Lowe
Executive Officer



METHODOLOGY

Fi Mercer, of Fi Mercer Coaching Pty Ltd, facilitated five membership and key stakeholder forums to ascertain key themes for the Strategic Plan. We conducted the forums at various geographical locations throughout the region. This was to ensure broad input and feedback into this process. The forums were as follows:

Casterton	18 August 2009
Hamilton	18 August 2009
Warrnambool	19 August 2009
Portland	19 August 2009
Geelong	20 August 2009

Twelve key themes emerged from this process. Subsequently, we held an Executive Committee planning forum on the 27 August 2009, At this forum we created a vision and prioritised the key focuses for the next three years.

To assist us in developing this Strategic Plan we were guided by the regional health and wellbeing priorities, as identified by the Department of Health (DH) Barwon South-West region, the Great South Coast planning priorities and the SGGPCP health promotion priorities. We also analysed key data and relevant policies.

From this information we developed a "Strategic one-pager" which outlines our future focus. This one-pager was accepted by the Executive Committee in September 2009 and work commenced on detailing the plan and supporting documents.

We distributed the draft Strategic Plan to all members and stakeholders in November 2009, seeking comment and advice. Fifteen organisations provided feedback and we incorporated their advice into this Strategic Plan.



This document is structured into three sections. There are also two separate supporting documents.

1. ***Strategic One Pager (Page 4)***

The strategic one-pager, details the vision and goals of the Partnership. The goals are set under three headings being **Community Health and Wellbeing Priorities**, **Collaboration Enablers**, and **PCP Deliverables**.

In our role of building capacity for collaboration, we have determined key ways to build that capacity within our membership – these are known as the **Collaboration Enablers**.

We will frame all of our work around these **Collaboration Enablers** with the **Community Health and Wellbeing Priorities** as the focus. The Department of Health has also set key deliverables which we are required to meet. These are known as **PCP Deliverables** and these are woven throughout the **Collaboration Enablers** and this Strategic Plan.

2. ***Strategic Plan 2009-2012 (Page 5)***

This section details what we are going to do to reach the goals.

3. ***Targets and Reporting (Page 8)***

This section details what we aim to achieve and how we are going to measure this.

SUPPORTING DOCUMENTS

Action Plan 2009-2012

We have developed the Action Plan to detail how we are going to achieve the key strategies identified in the Strategic Plan. The Action has specific actions for each strategy, nominates who is responsible and allocates a broad timeframe. The Action Plan is our working tool and it will be reviewed annually and adapted to suit our changing needs. Please visit the PCP website for a copy of the Action Plan 2009-2012 at www.sggpcp.com

Strategic Plan 2009-2012 Background Report

We undertook various analyses to ensure the data supported the intended priorities. This information is collated in our Background Report and this can be downloaded from the website www.sggpcp.com



OUR VISION:
*Through capacity building for collaboration,
 enhance the health and wellbeing of our community*

COMMUNITY HEALTH AND WELLBEING PRIORITIES

Improve health equity in vulnerable communities

We will improve the health and wellbeing outcomes for low socio-economic communities using an integrated location based approach

We will Improve the health and wellbeing outcomes for

- Indigenous people
- People with a disability
- Farm families
- People ageing at home
- Children and young people

Mitigate and adapt to climate change

We will reduce the impact of climate change on vulnerable groups.

We will reduce our emissions

We will strengthen communities to adapt to climate change

Develop healthy and liveable communities with a focus on mental health and wellbeing, and diabetes prevention and management

We will increase our community's mental health and wellbeing through ensuring it is everybody's business

We will slow the trend of the increasing prevalence of diabetes

We will improve so that consumers with diabetes or mental health issues experience client-centred, equitable and best practice health care

COLLABORATION ENABLERS

1. Strengthen partnerships

Through a focus on governance effectiveness and relationships, we will have the capacity for a flexible and collaborative approach to addressing the Community Health and Wellbeing Priorities.

2. Facilitate integrated planning

We will have a coordinated approach to addressing the Community Health and Wellbeing Priorities as a result of integrated planning.

3. Build health services and community capacity

We will have an increased capacity for a sustainable collaborative approach to addressing the Community Health and Wellbeing Priorities.

4. Improve systems and processes to provide better access to safe and continuous services

We will have a co-ordinated approach for addressing Community Health and Wellbeing Priorities as a result of improved systems and processes.

PCP DELIVERABLES

Partnerships

We will have a strong collaborative partnership that enables improved mental health and wellbeing, reduce the prevalence and impact of diabetes for the community, especially for vulnerable groups.

Integrated Health Promotion

The community, especially vulnerable groups are more physically active and socially connected and have improved food security, oral health and transport options.

Chronic Disease Management

Consumers with diabetes or chronic mental health conditions, especially from vulnerable groups, experience a co-ordinated health system and quality health care, centred on support to optimise their health and quality of life.

Service Coordination

Consumers, especially those from vulnerable groups, experience an accessible and coordinated health system.



COLLABORATION ENABLERS	1 STRENGTHENING PARTNERSHIPS
GOAL	Through a focus on governance effectiveness and relationships, we will have the capacity for a flexible and collaborative approach to addressing the Community Health and Wellbeing Priorities.
STRATEGIES	
1.1.	We will provide a supportive environment for having the right partnership, at the right time and for the right reason, by expanding and strengthening our relationships with key people, organisations and networks.
1.2.	We will respond to emerging local needs and opportunities with leadership and innovative solutions, particularly in the areas of community art, climate change and community development.
1.3.	We will keep abreast of changes to primary care from the national reform and proactively review our strategies to ensure the best transition for our community.
1.4.	We will continue to improve the governance and processes of our Partnership.
1.5.	We will ensure that the Partnership is effective and timely by developing a business plan and monitoring our results.
1.6.	We will provide easy and effective communication and knowledge exchanging processes and tools such as our website, newsletters, media orientation programs and network meetings.

COLLABORATION ENABLERS	2 FACILITATING INTEGRATED PLANNING
GOAL	We will have a coordinated approach to addressing the Community Health and Wellbeing Priorities as a result of integrated planning.
STRATEGIES	
2.1.	We will improve the integration of health and wellbeing planning by convening the integrated planning subcommittee and developing integrated plans for mental health, diabetes prevention and drugs and alcohol.
2.2.	We will gather and share priority local data, research findings and policies to assist members in planning and making decisions.
2.3.	We will develop integrated health promotion plans to improve physical activity, social connection, food security, oral health and transport options for our community.
2.4.	We will implement our integrated health promotion plans.

COLLABORATION ENABLERS	3 BUILD HEALTH SERVICE AND COMMUNITY CAPACITY
GOAL	We will have an increased capacity for a sustainable collaborative approach to addressing the Community Health and Wellbeing Priorities.
STRATEGIES	
3.1.	We will improve our members' participation in collaborative approaches by understanding our collective skill needs and co-ordinating local training opportunities.
3.2.	We will improve our members' ability to manage change in the workplace by understanding our collective needs and co-ordinating local training opportunities.
3.3.	We will improve our understanding of vulnerable communities by understanding our collective needs and co-ordinating local training opportunities.
3.4.	We will increase our members' ability to provide best practice clinical care and support people to manage their diabetes or mental health issues by understanding our collective needs, exchanging knowledge and co-ordinating local training opportunities.
3.5.	We will increase our members' ability to deliver integrated health promotion initiatives through networking, exchanging knowledge and accessing training opportunities.
3.6.	We will seek or support others in obtaining or sharing resources for collaborative initiatives that address our priorities.
3.7.	We will seek or support others in obtaining or sharing resources for community capacity building programs that target vulnerable groups or locations.

COLLABORATION ENABLERS	4 IMPROVE SYSTEMS AND PROCESSES TO PROVIDE BETTER ACCESS TO SAFE AND CONTINUOUS SERVICES
GOAL	We will have a co-ordinated approach for addressing Community Health and Wellbeing Priorities as a result of improved systems and processes.
STRATEGIES	
4.1.	We will provide easy access to priority data, evidence, information and policies for our members.
4.2.	We will assist in improving the accessibility of health and wellbeing services for young people and for people in small communities.
4.3.	We will improve the co-ordination and consistency of services by expanding the use of standard referral tools, developing local agreements and working towards shared care planning for consumers with complex conditions.
4.4.	We will support members to continuously improve their service co-ordination and chronic disease management practices by undertaking an annual survey and promoting the Continuous Improvement Framework.



TARGETS & REPORTING

THREE YEAR KEY OUTCOMES TARGETS AND REPORTING MECHANISMS		
	TARGETS	REPORTING MECHANISMS
COLLABORATION ENABLERS		
<p>1. STRENGTHENING PARTNERSHIPS <i>Through a focus on governance effectiveness and relationships, we will have the capacity for a flexible and collaborative approach to addressing the Community Health and Wellbeing Priorities</i></p>	<p>A. By December 2010, the reviewed PCP Governance structures and reporting processes shall be in place to support the implementation of the Strategic Plan</p> <p>B. By June 2012, membership shall include appropriate representation on behalf of the priority vulnerable groups</p> <p>C. An annual report and review of the Action Plan and the development of detailed business plan and budget shall be undertaken</p>	<ul style="list-style-type: none"> • Annual Partnership Reporting Tool • Annual Case Study • Annual audited financial report • Quarterly Activity Reporting (Internal)
<p>2. FACILITATING INTEGRATED PLANNING <i>We will have a coordinated approach to addressing the Community Health and Wellbeing Priorities as a result of integrated planning.</i></p>	<p>A. By June 2012, an integrated strategy for mental health is being implemented by appropriate members</p> <p>B. By June 2012, an integrated strategy for diabetes is being implemented by appropriate members</p> <p>C. By June 2012, the membership shall report an increase in accessible data and evidence to support their decisions via the PCP</p> <p>D. By June 2010, integrated health promotion plans shall be developed for food security, physical activity, social connection and oral health</p> <p>E. By June 2012, health promotion interventions for food security, physical activity, social connection, oral health and transport shall be delivered as per the plans and evaluated and reported using set indicators</p>	<ul style="list-style-type: none"> • Annual Case Study • Annual integrated health promotion indicator reporting • Membership survey (to be developed) • Quarterly Activity Reporting (internal)

THREE YEAR KEY OUTCOMES TARGETS AND REPORTING MECHANISMS

	TARGETS	REPORTING MECHANISMS
COLLABORATION ENABLERS		
<p>3. BUILD HEALTH SERVICE AND COMMUNITY CAPACITY</p> <p><i>We will have an increased capacity for a sustainable collaborative approach to addressing the Community Health and Wellbeing Priorities.</i></p>	<p>A. Between 2009 and 2012, all members have reported being part of at least one new collaborative or co-ordinated initiative or program</p> <p>B. By June 2012, 90% of relevant members participate annually in the Integrated Chronic Disease Management Survey</p> <p>C. By June 2012, there is an improvement in quality of care provided by the membership for consumers with a chronic disease as measured by the Integrated Chronic Disease Management Survey</p> <p>D. Annually, PCP brokers over \$200,000 collaborative initiatives to address Community Health and Wellbeing priorities</p> <p>E. Annually, PCP supports or partners in over \$500,000 collaborative initiatives to address Community Health and Wellbeing priorities</p>	<ul style="list-style-type: none"> • Annual Case Study • Annual Integrated Chronic Disease Management Survey • Quarterly Activity Reporting (internal)
<p>4. IMPROVE SYSTEMS AND PROCESSES TO PROVIDE BETTER ACCESS TO SAFE AND CONTINUOUS SERVICES</p> <p><i>The Partnership has a co-ordinated approach for addressing "Community Health and Wellbeing Priorities" as a result of improved systems and processes.</i></p>	<p>A. By June 2012, all members report on increase in communication, accessing and sharing information (measure to be developed)</p> <p>B. By June 2012, 90% of relevant members participate annually in the Service Co-ordination Survey</p> <p>C. By June 2012, there is an increase in co-ordination for addressing the Community Health and Wellbeing priorities as measured by the Service Co-ordination Survey</p>	<ul style="list-style-type: none"> • Annual Case Study • Annual e-referral report • Annual Service Co-ordination Survey • Quarterly Activity Reporting (internal)