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inner east
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Catchment Planning Framework for Health and Wellbeing

A guide to integrated planning in local government, community health and women's health in Melbourne's Inner East

Developed by Keleher Consulting for the Inner East Primary Care Partnership

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Contents

Abbreviations

ACIR   Australian Childhood Immunisation Register

AEDC   Australian Early Development Census

AIHW   Australian Institute of Health and Welfare

CHS   Community Health Service

CIV   Community Indicators Victoria

DEECD Department of Employment, Education and Early Childhood

DHHS   Department of Health and Human Services

DHS   Department of Human Services

DHSV   Dental Health Services Victoria

EGM   Electronic Gaming Machine

EMSIC Eastern Metropolitan Social Issues Council

IEPCP   Inner East Primary Care Partnership

LGA   Local Government Area

MCH   Maternal and Child Health

NHPAs National Health Priority Areas

SDH   Social Determinants of Health

SEIFA   Socio-Economic Index For Areas

VPDC   Victorian Perinatal Data Collection

VPHS   Victorian Population Health Survey

VPHWP Victorian Public Health and Wellbeing Plan

WHS   Women's Health Service

The Inner East Primary Care Partnership (IEPCP) is one of 28 Victorian Primary Care Partnerships (PCPs) that cover metropolitan, regional and rural areas throughout the state. The IEPCP catchment area has a population of 608,000 people, which is 11.7% of the State population.

The catchment comprises the four local governments of Boroondara, Manningham, Monash and Whitehorse, four Community Health Services (CHS): Inner East CHS, Carrington Health (City of Whitehorse), Manningham CHS, and Link Health and Community (City of Monash), and Women's Health East which is the regional service for the Victorian DHHS Eastern Metropolitan Region.

1.   Introduction

The Department of Health and Human Services (DHHS) has moved to a unified planning cycle that supports joint planning particularly between local government, community health and women's health services. Primary Care Partnerships have led collaborative prevention work for over 15 years and have considerable experience in facilitating partnership development as well as supporting agencies in the planning and evaluation of preventative health initiatives.

Taking the view that "Together we do better", the Inner East Primary Care Partnership has commissioned this work with the view to identifying opportunities for improved collaboration in the development of prevention plans across the inner east of Melbourne.

This document identifies key opportunities for collaboration across the Inner East through agreement on core data and indicator sets, collaboration on consultation processes, joint identification of shared priorities and agreed approaches to evaluation. There is already considerable collaborative prevention work happening across the catchment, in particular in the areas of Food Access and Security, Prevention of Violence Against Women, Prevention of harm from drugs and alcohol and improving social connectedness.

There are a number of planning forums and governance structures that support this work and the Eastern Metropolitan Region has a very strong history of collaboration:
- The Eastern Metropolitan Region Social Issues Council is taking a strategic and evidence based approach to family violence and strengthening social connectedness/reducing social isolation.
- Women's Health in the East is leading a region-wide strategy to prevent violence against women: "Together for Equality and Respect".
- The Alcohol Flagship currently chaired by the two Eastern Metro PCPs focuses on upstream prevention of harm.

- The Inner East Food Think Tank - led by Inner East Primary Care Partnership focuses on collaborative action to improve access to healthy and nutritious food.

The Eastern Melbourne PHN has a key role in health planning and together with Eastern Health, the Connect 4 Health Community Health Services, and a range of other services in the catchment including the PCP's has formed the Eastern Primary Health Care Collaborative. The focus of this work is strongly on commissioning, service improvement and preventable hospitalisations, particularly of those with chronic and complex needs. This work is quite separate from the upstream focus of this planning framework, however, it should be noted that the upstream prevention work provides a very important pillar for supporting the downstream work of the primary care collaborative.

1.1   About this project

This Planning Framework Project was commissioned by the Inner East Primary Care Partnership on behalf of its member agencies. The brief for the project includes completion of a planning document that:
- Analyses the current policy environment and advises how to integrate this into the planning process
- Seeks to establish common elements of needs analysis
- Identifies core data sets and key health indicators
- Recommends key processes and questions for community consultation
- Discusses a range of frameworks or lenses and how these can be used to interpret the needs analysis for example: The Social Determinants of Health, Gender Equity, Liveability indicators
- Recommends approaches to evaluation and appropriate tools.

The aim of the project is to development a planning approach for the local governments, community and women's health services in the Victorian LGAs of Boroondara, Manningham, Monash and Whitehorse. Currently agencies have overlapping responsibilities for the population's health and wellbeing, yet in general, they tend to operate in isolation from one another despite sharing common interests in relation to the health of their shared populations. This Planning Framework is intended to make cross-sectoral collaboration for health and wellbeing more feasible and productive. The value of data sets is that they facilitate the measurement and evaluation of change because the indicators make clear what factors are measured in each domain.

The objectives for the Planning Framework project are that it:
- Demonstrates good practice in planning and the consistent integration of contemporary theory
- Supports collaborative planning
- Helps to identify key indicators for health and wellbeing and links these to evaluation strategies
- Facilitates collective identification of areas for joint work to enhance collective impact
- Helps to standardise planning and evaluation processes
- Strengthens common understanding of local issues
- Articulates the partnership opportunities arising from joint planning.

This guide is designed to support a consistent approach to planning and to strengthen partnerships between sectors and organisations for the improved health and wellbeing of populations across the catchment. Importantly, the guide is intended to increase inter-sectoral action for health improvement across the Inner East.

2. Definition of catchment planning

Catchment Planning is a means of thinking through, and taking action on, the most significant issues affecting the health and wellbeing of a population group or community. It focuses on the ways an integrated, collaborative partnership approach can bring organisations and service agencies together with relevant key stakeholders to create a greater impact than can be achieved by those agencies working alone.

Catchment planning is supported in Victoria to strengthen cross-agency and inter-sectoral planning particularly for complex issues, alongside increasing recognition that complex health and social issues require new approaches. Complex problems require solutions that involve multiple agencies, organisations and communities to coalesce around shared interests.

3. Population Health Planning Framework

The Victorian Healthcare Association (VHA) Population Health Planning Framework is a useful tool for population health planning, which can be found at the following link and below in Figure 1: http://www.populationhealth.org.au/index.php/the-vha-framework/planning-framework-diagram.

Figure 1 - VHA Population Health Planning Framework

It outlines the steps involved in population health planning:
- the development of a vision/goal
- six core planning components

- six guiding principles that represent the activities and principles required to implement a best-practice approach.

Specific approaches to population health planning in different areas will however differ depending upon the nature of the partnerships developed and the characteristics of communities and populations being targeted.

Each element of the framework is explained in more detail in the toolbox section of the VHA website:
- Resources can be found here: http://www.populationhealth.org.au/index.php/the-vha-framework/the-resources
- The Toolbox can be found here: http://www.populationhealth.org.au/index.php/the-vha-framework/the-toolbox

4.   Policy context

Various policies and plans at the federal, state and local level inform catchment planning undertaken by local government, CHS and WHS, and inform their priorities.

4.1 National Health Priority Areas

The National Health Priority Areas (NHPAs) are diseases and conditions that Australian governments have chosen for focused attention because they contribute significantly to the burden of illness and injury in the Australian community. The AIHW publishes information on the NHPAs and their associated indicators and risk factors across the Australian population with a focus on particular population groups of interest[1].

The 9 NHPAs are:
- Cancer control (first set of conditions, 1996)
- Cardiovascular health *(first set of conditions, 1996)*
- Injury prevention and control (first set of conditions, 1996)
- Mental health (first set of conditions, 1996)
- Diabetes mellitus (added 1997)
- Asthma (added 1999)
- Arthritis and musculoskeletal conditions (added 2002)
- Obesity (added 2008)
- Dementia (added 2012*)*

4.2 Victorian Public Health and Wellbeing Act 2008

The Victorian Public Health and Wellbeing Act 2008 requires Councils to develop a Municipal Public Health and Wellbeing Plan every four years following the council election process. Under the requirements of the Act, the Municipal Public Health and Wellbeing Plan must:

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[1] AIHW. National Health Priority Areas. Available: http://aihw.gov.au/national-health-priority-areas/, accessed 20 March 2016.

- Examine data and evidence on health and wellbeing
- Involve the local community in its development
- Identify strategies to achieve maximum health and wellbeing of the community
- Specify how Council will work in partnership with other agencies to accomplish the strategies; and
- Provide a consistent message to that in the Council Plan and Municipal Strategic Statement.

The aim of the Victorian Public Health and Wellbeing Act 2008 is to achieve the highest attainable standard of public health by reducing health inequalities, promoting environments in which people can be healthy, and the protection and prevention of disease, illness, injury, disability and death.

The Victorian Public Health Act recognises that local government is a major partner in efforts to protect public health and wellbeing. The Act states that in preparing their plans, Councils must have regard to the Victorian Public Health and Wellbeing Plan 2015-2019.

4.3 Victorian State Government Policy

Health promotion and prevention efforts in the local area are encouraged to be at scale, based in settings and focused on addressing the underlying causes of ill health. Prevention efforts should be aligned and mutually supporting to deliver collective impact on the health of the local population, focused on delivering long term outcomes for local communities with shared local indicators established to assess progress in the shorter-term.

In considering how to best improve the health and wellbeing of the community the Victorian Department of Health and Human Services supports organisations to consider a range of elements (governance arrangements, staff placement) to promote bringing resources together across a catchment.

4.3.1 The Victorian Public Health and Wellbeing Plan

The Victorian Public Health and Wellbeing Plan (VPHWP) 2015-2019 establishes priorities for action and identifies place-based approaches as a key platform for change, alongside healthy and sustainable environments and people-centered approaches.

The Victorian Public Health and Wellbeing Plan 2015-2019 has an explicit aim to reduce inequalities in health and wellbeing. It identifies challenges to the health status of Victorians including:
- increases in some risks to health and only limited or no improvement in others particularly obesity and physical abuse associated with alcohol
- the increasing impact of chronic disease
- persistent inequalities in health status
- demographic trends that require new approaches including population ageing, the need for an increased focus on the health and wellbeing of health and families
- environmental sustainability and health protection including the impact of climate change, the spread of communicable diseases and the emergence of new diseases, and the need for communicable disease planning and preparedness.

The priorities identified by the plan are put forward as stepping stones towards outcomes to be achieved by 2025 and are a guide to action across all sectors:

- healthier eating and active living
- tobacco free living
- reducing harmful alcohol and drug use
- improving mental health
- preventing violence and injury
- improving sexual and reproductive health.

Acknowledgement is also given in the plan to the role of the state in providing safe, healthy and sustainable environments to protect and secure the health and wellbeing of Victorians.

4.4 Local government policy context

The Public Health and Wellbeing Act 2008 requires the Minister for Health to deliver a state public health and wellbeing plan every four years to establish the foundations for prevention and population health for that period and into the future.

Under The Act 2008 Victoria's local governments have a legislated responsibility for public health and wellbeing. Through the development and delivery of local Municipal Public Health and Wellbeing Plans, local governments provide strategic leadership for prevention in local communities.

The VPHWP identifies local government as a major partner, and the VPHWP priorities provide a guide to action for Municipal Public Health and Wellbeing Plans (MPHWP). Detailed actions of the VPHWP are included in topic-specific plans such as: cancer; 10 year mental health; HIV/AIDS; Ice; oral health; skin cancer prevention; Koolin Balit etc. The Plan is accompanied by an Outcomes Framework that will describe population level outcomes and measures, and provide a means of assessing the impact of Victoria's collective efforts.

The VPHWP is built on a "systems thinking" perspective and establishes a clear line of sight between statewide policy and local action for partners to work together with the community to develop a single plan - with agreed priorities, activities and indicators that meet the legislated requirements of MPHWP.

Councils have the option to include public health matters in the Council Plan or other strategic plans. This provides councils with an alternative way of considering and documenting the public health and wellbeing goals and strategies. It does not change what is required of councils for municipal public health and wellbeing planning as set out in the Public Health and Wellbeing Act 2008.

4.4.1 Environments for Health

Planning by Victoria's local governments is framed by the Victorian Department for Health document, Environments for Health[2] which is built on the four pillars of the built, economic,

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[2] Victorian Department for Health. Environments for Health: Municipal Public Health Planning Framework. 2001.

social and cultural environments. Every Victorian LGA is required to provide a Municipal Public Health and Wellbeing Plan within 12 months of the general Council election.

There is increasing emphasis in MPHWB Plans on liveability, whereby goals and outcomes are identified based on available evidence for achieving maximum health and wellbeing within the community. The pillars for liveability in LGA plans in the Inner East include sustainability, equity, social inclusion, community safety and resilience. Many (but not all) of these themes are also identified in the Victorian Health and Wellbeing Plan 2015-2019.

4.4.2 Plan Melbourne

Since 2014, local government planning has been strongly informed by the policy context provided by Plan Melbourne, and Plan Melbourne Refresh, 2015.[3]   The priorities of Plan Melbourne Refresh include:
- A changing economy
- The demands of providing infrastructure across a greater area to more people
- A growing and ageing population
- A changing climate
- Meeting demands for diverse housing.

These priorities are highly consistent with the social determinants of health and demonstrate the relevance of local government for coalitions and partnerships to address health and wellbeing across the IEPCP catchment.

4.5 Impending policy directions

At the time of finalising this report, there were several policies in development which are likely to have an effect on planning in the IEPCP catchment:

- The Victorian Royal Commission on Family Violence report was released in March 2016 and contained 227 recommendations. Future policy is likely to focus on improving the foundations of the current system, identifying opportunities to transform the way that we respond to family violence, and building the structures that will guide and oversee a long-term reform program that deals with all aspects of family violence. Recommendation 94 specifically states "The Victorian Government amend section 26 of the Public Health and Wellbeing Act 2008 (Vic)— which requires that councils prepare a municipal public health and wellbeing plan—to require councils to report on the measures the council proposes to take to reduce family violence and respond to the needs of victims. Alternatively, the Victorian Government could amend section 125 of the Local Government Act 1989 (Vic)—which requires each council to prepare a council plan—to require councils to include these measures in their council plan (rather than their health and wellbeing plans) [within 12 months].

- Outcomes Framework for the VPHWP. The Outcomes Framework is being developed by the Health Innovation and Reform Council, and is due to be released in mid-2016. The Framework is intended to be a mechanism for:

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[3] Plan Melbourne Refresh : http://refresh.planmelbourne.vic.gov.au/plan-melbourne-refresh-discussion-paper

a. helping to understand how well the health system is performing in relation to its purpose and priority outcomes (including patient experiences, efficiency and effectiveness);
b. signalling the need for and driving performance improvement;
c. helping to monitor the impacts of improvement efforts over time;
d. improving transparency, accountability and value of the health system.

The Outcomes Framework sets out two high-level outcomes:

- Outcome 1: Optimised healthy life, (e.g. reduced days of disability and years of life lost, health quality as well as length of life and patient experience of care)
- Outcome 2: Optimised system outcomes, productivity, and sustainability (value for money).[4]

The emphasis on redressing health and social inequities in the VPHWP is expected to be central to the Outcomes Framework. Planning by health agencies in particular will need to take account of this Outcomes Framework.

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[4] Department of Health and Human Services. Health and Wellbeing Outcomes Framework.
https://www2.health.vic.gov.au/about/publications/researchandreports/Health%20and%20Wellbeing%20Outcomes%20Framework

5.   Needs assessment

Needs assessment rarely begins with a blank slate, so first determine the strength of the data that your organisations have gathered to date, and then decide what further data collection is required. There is likely to be a large amount of data available to the partnership. Identify who will take responsibility for gathering additional data and its analysis in order to identify key themes.

A needs assessment should consider all demographic data, key stakeholder and community consultations to identify catchment needs, priority groups identified from the data, what is known and what is not known. Local knowledge of stakeholders and consumers should be included to critically analyse the strength of the evidence, and the determinants of the priority to be addressed.

5.1 What is an indicator for population health and wellbeing?

An indicator provides evidence that a certain condition exists or certain results have or have not been achieved. An indicator is a statistic that extracts the best possible information from a data source that can be regularly monitored[5]. Health indicators are summary measures that describe particular aspects of health or health system performance that also identify the underlying trends when monitored over time.

Another way of describing an indicator is that it is 'a variable with characteristics of quality, quantity and time used to measure, directly or indirectly, changes in a situation and to appreciate the progress made in addressing it". [6]

So, indicators can be progress measures (how well are we doing?) and/or of outcome measures (have we changed anything?).

This planning document provides key indicators for catchment planning for health and wellbeing, organized into data sets and sources where they can be obtained. The data sets are based on domains derived from existing priorities of the IEPCP partners in this project as well as the Victoria Public Health and Wellbeing priorities, and a life-course approach.

Indicators for health and wellbeing used in the current plans of the agencies involved with this project come from nationally or state-wide administrative sources (i.e. government), surveys administered by agencies such as VicHealth, and local/regional surveys. These sources are supplemented by data from community consultations.

5.2 Domains for indicators and core data sets

The domains for the core data set for this project are provided to assist with the understanding and presentation of the various health and wellbeing concepts that are used for planning. The indicators are organised into core data sets by domains of health and wellbeing across the lifespan. Indicators are grouped into these eleven domains:

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[5] AIHW. 2015. Population health FAQ. Available: http://www.aihw.gov.au/population-health-faq/
[6] Gruskin S, Ferguson L. Using indicators to determine the contribution of human rights to public health efforts. *World Health Organization Bulletin.* 2009; 87:714-719; Public health indicators: http://www.health.gov.on.ca/en/public/publications/pubhealth/init_report/indicators.html

Demographics	Socio-economic & social gradient	Infant years & childhood	Adolescence
Ageing	Health status	Food security & healthy eating	Gender equity
Mental health	Housing & homelessness	Liveable neighbourhoods	

Appendix A provides an overview of each of these domains, explaining their relationship to the social determinants of health and inter-relationships across other domains, and the indicators that make up the core data set. It is critical that indicators are used together in planning and not in a selective manner that treats a single indicator as a stand-alone measure.

5.3 Community engagement and consultation

The term, 'community engagement' can cover consultation, communication, public participation, participative democracy or working in partnership. 'Community engagement' a generic, inclusive term to describe the broad range of interactions between people.

A variety of approaches are utilized including one-way communications for the purposes of or information delivery, community consultative processes, getting communities involved in decision-making, and efforts to empower individuals and groups through empowered action in informal groups or formal partnerships.

Community consultation is a structured approach to gathering data, mapping issues of concern to communities, in order to incorporate community views into planning.

Regular community engagement work for consultation and research is undertaken by Councils in the Inner East to inform the development and implementation of a range of Council policies and strategies. Local governments involved in this project are closely engaged with community consultation which is conducted across different departments/areas of Council, using a range of different methods. These may be through Community Advisory Groups, or invitations to review plans and strategies and comment, or forums. Local government community consultations are also about specific issues such as zoning, open spaces, residential, sporting or commercial developments, or public transport. Another method used in the City of Monash is Listening Posts: http://www.monash.vic.gov.au/About-Us/Council/Have-Your-Say/Listening-Posts-in-local-neighbourhoods

Community Health and Women's Health Services also engage in community consultation albeit with smaller financial capacity than local government, to do this work. Recent collaborative consultations include focus groups and interviews for the Diabetes Access Project undertaken by Inner East PCP, Outer East PCP and Carrington Health: http://www.iepcp.org.au/sites/default/files/Diabetes%20Access%20Project%20Final%20Report%20Sept%202015.pdf

Other examples include the Manningham Community Health Service Community Champions Advisory Group, and consumer consultants to provide feedback and advice on specific programs: https://www.mannchs.org.au/wp-content/uploads/2014/12/2015-11-18-MANNCHS-Annual-Report-20151.pdf .

Appendix B provides the IAP2 Spectrum of Public Participation which sets out the different purposes and methods for consultation.

There is a great deal of willingness across agencies for collaborative work on community consultations. CHS and WHS in particular, have the capacity to reach some populations, particularly vulnerable groups, where local government may not have the connections. By working together on community consultations, all agencies have opportunities to tailor the questions to provide information that have mutual benefit.

5.4 Data analysis and triangulation

One dimensional information is almost never sufficient to really understand health and wellbeing issues which is why triangulation methods are used.

Triangulation is about using evidence from different types of data sources, such as interviews, documents, questionnaires or surveys within the same study or needs assessment. Data triangulation validates data and research by cross verifying the same information. Triangulation minimises bias, and helps to understand the depth of the causes and the multiple dimensions of issues because:

- Additional sources of information often give more insight into a topic
- Inadequacies found in one-source data is minimised when multiple sources confirm the same data
- Multiple sources provide verification and validity while complementing similar data
- More comprehensive data is obtained
- Data and information is supported in multiple places/types of research, which makes it easier to analyze data to draw conclusions and outcomes
- Inconsistencies in data sets are more easily recognised.

For example, the themes from interviews with stakeholders can be cross verified through focus groups or workshops with consumers. Community consultation data will also provide broad themes which can be examined with broader stakeholders to deepen understanding of the issues which in turn, provides knowledge that informs how effective strategies for action are designed.

Using the example of Alcohol and Other Drugs (AOD) prevention (see below), the needs assessment process would start by identifying stakeholder groups such as community leaders, youth, teachers, and health providers. In-depth interviews or surveys would be conducted with each of these groups to gain insight into their perspectives, beliefs and attitudes. Each of the data sources will be analysed separately and then using the method of triangulation, the findings will be compared to determine areas of convergence and agreement. This may show that some aspects of the findings need further clarification with follow-up methods such as roundtables or workshops of key stakeholders and consumers. These processes establish the reliability of the needs assessment as the basis for the program work which will follow.

In summary, triangulation methods provide a clearer understanding of the problem, ensures that differing perspectives are included, and increases confidence in the needs assessment data.

5.5 Example of needs assessment for Alcohol and Other Drugs

This section provides a further example of planning for the prevention of harms from Alcohol and Other Drugs that includes sources for a gender lens, and triangulation.

The first step is to review the data about alcohol and drug misuse and then determine the long-term indicators on which the prevention program will be focused. The following long-term indicators are taken from Appendix A. The Partnership will need to decide which of these indicators are relevant.

Examine data	• Proportion of young people who misuse alcohol, nicotine, illicit drugs • Source: DEECD Adolescent Health Profile 2010 • Proportion of young adults who misuse alcohol, nicotine, illicit drugs • Proportion of mid-life and older adults who misuse alcohol, nicotine, illicit drugs • Source: Victorian Population Health Survey 2013 • Victorian Population Health Survey of People with an Intellectual Disability 2013 • Numbers of people with co-occurring substance misuse and mental health disorders • Source: Eastern Metropolitan Region – Mental Health and Alcohol & Drug Catchment Plan 2016- 2018

Select long-term indicators for focus of prevention	• Rates of alcohol misuse in teenagers have decreased • Rates of tobacco use in teenagers have decreased • Rates of illicit drug use in teenagers has decreased • Rates of alcohol use in adults has decreased • Rates of tobacco use in adults has decreased • Rates of illicit drug use in adults has decreased • Rates of alcohol use among people with intellectual disability have decreased • Rates of tobacco use among people with intellectual disability have decreased • Rates of people with dual disability with decreased substance misuse

Then:
- Determine the strength of the data that your organisations have gathered to date about the priority, and what further data collection is required.
- Identify the gendered aspects of AOD, to ensure that you have reliable data for evidence based decisions for prevention program planning. There is considerable literature on gender differences for a whole raft of issues but the box below provides links to specific resources on gender and AOD.

| Use a gender lens to better understand the complexity of AOD issues and impacts | Gender trends in alcohol consumption Australian Bureau of Statistics 2013 *4125.0 – Gender indicators, Australia, Jan 2013 – Consumption of alcohol* (http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4125.0main+features3310Jan%202013).

Women and smoking: http://www.quit.org.au/resource-centre/media/media-backgrounders/pages/women-smoking.aspx

Tobacco Control Key Facts and Figures: http://www.quit.org.au/resource-centre/media/media-backgrounders/pages/women-smoking.aspx

Working with Women engaged in AOD Treatment (includes gender specific information about women and AOD): http://nada.org.au/resources/nadapublications/resourcestoolkits/women'saodresourc**e/**

Australian Women's Health Network Position Papers on Women, Health and Wellbeing, and Women and Non-Communicable Disease: **http://awhn.org.au/position-papers/** |
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Then:
- Scope the extent of community consultations conducted on AOD in the last three years. On the basis of that, determine the gaps in information that can be informed by consultations with stakeholders and communities.
- Questions for community consultation need to be appropriate for the prevention issue and target groups, and designed to fill gaps in knowledge
- Consultation with multiple stakeholder and community groups about the prevention of AOD misuse in local catchments, is necessary to achieve sound understanding of the complexity of the issues.
- For AOD, the Victorian Alcohol and Drug Strategy Community Consultation (http://docs2.health.vic.gov.au/docs/doc/Whole-of-government-Victorian-alcohol-and-drug-strategy---Community-Consultation - pp 19-20) includes the questions that were asked of stakeholders which may provide a guide. There are also multiple submissions for this review available online which provide a comprehensive overview of stakeholder perspectives.

Then:
- Triangulate your data as outlined in Section 5.4
- Decide the type of partnership that is needed for collaborative approaches to address the prevention of AOD misuse, and that can be supported by the partnership.

6. Collaborative planning approaches

Partnerships structures can influence the strength of collaborative outcomes achieved from the efforts of a partnership. Through the identification of priority issues, local information and knowledge is shared by agencies, which in turn, improves capacity for integrated planning and practice for prevention designed to create healthier communities.

6.1 Systems thinking

At its most fundamental, systems thinking requires understanding of how systems work. As you examine the systems at work that determine the problem you are addressing, you will find the inner logic of social norms, or relationships or causal pathways of the issue/s which you want to change. Most health and wellbeing issues are complex so recognising the complexity of the systems which impact on health and wellbeing is necessary.

For example, to impact on healthy eating and nutrition, a solid understanding of the multiple points of relevant systems including communities, schools, workplaces and governments at all levels and the health system, is necessary in order to develop a prevention plan. Recognising and mapping of complexity is also necessary in systems approaches in order to work out the leverage points where impact is required to strengthen prevention. This involves intervening at strategic leverage points to produce multiplier effects in order to achieve impact.

Systems approaches require about high-level policy and leadership to enable the scaling up of prevention interventions, while building a critical mass of leaders at all levels of the prevention system to enable improvements in population health.[7]

In a complex systems approach, practice, policy and research are all essential. They interact through feedback of knowledge about impacts and effects of interventions on key points in systems, and analysis of their potential to generate long-term positive effects.

The Healthy Together Victoria[7] program identified five essential building blocks for a systems approach to prevention:

- Leadership and governance
- A dynamic workforce that thinks about and acts through a systems lens
- Relationships to drive change
- Knowledge co-creation that leads to action
- Funding mechanisms.

Working within the system also means working across the levels - local, state, and national - because systems are about what everyone is doing. However, local governments work in political environments, so they find it difficult to commit to developing their plans collectively in an integrated fashion. Once priorities that have been signed off by Council, they can begin to work to address issues collectively using the principles of integrated planning for action and implementation.

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[7] Healthy Together Victoria.
http://www.education.vic.gov.au/Documents/childhood/professionals/profdev/A%20Systems%20Approach%20to%20Preventing%20Childhood%20Obesity%20across%20the%20Perinatal%20Period.pdf

6.2 Integrated approaches to planning

An integrated approach to planning is a positive way to influence services and systems towards more sustainable patterns of health and wellbeing. Integrated planning takes into account such issues as common health and wellbeing priorities, interdependencies between agencies for service delivery, cross-sector interactions, existing partnerships and opportunities for strengthening collective approaches to planning, implementation and evaluation.

Collectively, integrated plans for health and wellbeing will help to prioritise infrastructure and service improvements that are needed to meet community, organisational and government objectives for improved health and wellbeing.

An integrated plan is a tool for the comprehensive analysis of existing and future health and wellbeing systems within an area defined either by a single local government or grouping of local governments that have significant health and wellbeing issues in common, and who wish to work across boundaries.

Plans that are integrated across a planning area build meaningful partnerships between all levels of government in the delivery of integrated systems for health. They can also be used to support funding requests to local, State and federal sources for infrastructure improvements.

Integrated planning could be focused on particular populations in identified geographic areas, and/or particular issues such as ageing, children and families, or youth. Those foci could be narrowed to specific issues such as healthy childhoods or mental health.

6.3 Elements of integrated planning

Key questions to consider when setting out to develop an integrated program plan should include:

- A rationale for why this plan is being developed
- The aims and objectives of the plan
- The scale and scope of the plan
- How the plan and subsequent projects will be resourced
- The partners in the plan
- The common points for integration that have been identified
- The indicators that will measure the change
- The outcomes desired by the partners
- Identification of the mechanisms for integration and implementation
- Visual links of inputs and processes with data and outputs, impacts and outcomes
- Identification of the program information required by decision-makers
- The interventions or services planned for integration, and how they will be efficiently and effectively redesigned to achieve outcomes
- The timelines for the plans and short, medium and longer-term outcomes
- The methodology for the implementation of the plan
- How data collection will be linked
- How the plan will be evaluated.

It is important for integrated program plans to identify challenges and opportunities because some objectives and targets will be more difficult to achieve and will depend on the extent of the gap between the likely and desired future, the options available to overcome the gap and any barriers to the effective implementation of strategies.

Partnerships can be understood on a continuum from networking and coordination through to cooperation and collaboration, depending on the degree of commitment, resource sharing, interdependence, trust, and power among its members. Partnerships are frequently formed in response to the availability of a grant, or a desire to coordinate efforts around a particular issue. New more intense forms of partnership are emerging called 'Collective Impact'.

6.4 Collective Impact

Collective Impact is a shared and often organic approach to improve outcomes, consistently over time. Collective Impact is about transformational change. It is more than a partnership approach. It is a structured methodology for achieving lasting change that is about co-creation and sustained joint efforts to achieve agreed outcomes.

In a Collective Impact context, services and funders shift their mindset to an 'adaptive' or 'emergent' approach that is focused on working together on the complexity of the issues. Essentially, a Collective Impact initiative involves a cross section of stakeholders working collaboratively together to solve complex social problems and collectively seek to create impact together, rather than as individual organisations.

Five premises of Collective Impact are that:
- Isolated Effort, short term projects and 'simple' solutions will not solve complex problems
- No single organisation can create large-scale, lasting social change alone
- There is no "silver bullet" solution to systemic social problems
- Scaling or replicating one organisation or program will not solve most social problems
- Strong organisations are necessary but not sufficient for large-scale social change.

There are five principles commonly used to distinguish a Collective Impact initiative from other forms of partnership:

1. ***Common Agenda****:* All participants must have a shared vision for change including a common understanding of the problem and a joint approach to solving it through agreed upon actions

2. ***Shared Measurement****:* Collecting data and measuring results consistently across all participants ensures efforts remain aligned and participants hold each other accountable

3. ***Mutually Reinforcing Activities****:* Participant activities must be differentiated while still being coordinated through a mutually reinforcing plan of action

4. ***Continuous Communication****:* Consistent and open communication is needed across the many players to build trust, assure mutual objectives, and appreciate common motivation

5. ***Backbone Organisation****:* Creating and managing collective impact requires a separate organisation(s) with staff and a specific set of skills to serve as the backbone for the entire initiative and coordinate participating organisations and agencies.

Critical Success Factors for Collective Impact include:

- Inspiring leadership – sometimes called 'catalytic' leadership
- Achievement of a shared vision that has buy-in and commitment from all players
- Partners must be prepared to work through the inevitable struggles in achieving a shared vision
- Community leadership
- Skilled facilitation outside of the group.
- Finding and developing the indicators that will measure change
- Capacity for shared measurement - systems
- Discipline – to stay focused on the outcomes and keep partners on track
- Partners accept that they are accountable for outcomes
- Professional communication
- Sufficiently funded backbone organisation for the life of the plan's implementation.

Further information about Collective Impact can be found at:

- Collective Impact Forum http://collectiveimpactforum.org
- Collective Impact Framework: http://www.collaborationforimpact.com/collective-impact/

7. Intermediate outcomes

Intermediate outcomes are those achieved in the first 6-12 months of implementation. In evaluation, intermediate outcomes are measured against the **objectives** of the program. Intermediate outcomes are defined around individual, organisational and community levels as defined below, rather than high level population health indicators used in strategic planning.

VicHealth defines intermediate outcomes as occurring at three levels:
1. Individual level such as developing personal skills, health and wellbeing education, improving health literacy
2. Strengthening organisations, for example, bringing about change in organisations to increase their responsiveness to community needs
3. Strengthening communities, for example, providing environments that are safe, supportive and sustainable; communities that increase social inclusion and participation; development of health and social services to increase access and equity.

When data is collected about these intermediate outcomes, and link them to final impacts, it is possible to work out which actions were more effective in achieving the final impacts. Measuring intermediate outcomes permits programs to identify gaps in the program actions before the final evaluation that focuses on long-term outcomes. This allows the partnership to modify interventions and improve the chances of impacting on the final outcomes.

Sample questions to consider at this stage are:

. What seems to be working?
. What is the evidence that things are working?
. What needs to be changed?
. How do we know that we've been successful?
. Are we making a difference?

Table 3 below is an example of intermediate outcomes for a healthy eating program.

Table 1 - Example of intermediate outcomes for a healthy eating program

Individual	Organisational	Community
Programs are reaching individuals, groups and communities with communications about sugary drink consumption.	Organisations are working consistently in cross-partnerships to promote a reduction in sugary drink consumption.	Communities are openly supportive of healthy food choice programs.
Programs are designed to increase healthy food literacy among priority groups: children, young people and families.	Partnerships are implementing evidence informed strategies and actions.	Schools, sporting clubs and community organisations are aware of the effect on health of sugary drink consumption.
	Resource allocation for program implementation and evaluation.	Schools, sporting clubs and community organisations have removed sugary drinks from display.

8.   Long-term outcomes

Long-term health and wellbeing outcomes are about changes the program is focused on, over the long term. Government strategies are frequently planned for a 10 or even 20 year horizon, but for a catchment plan with local partnerships, a long-term outcome is defined from one to three or possibly five years.

Long-term outcomes are generally about changes in health or wellbeing status, or in the conditions of living. In evaluation, long-term outcomes should be related to the **goals** of the program. That means therefore, that the goals need to be realistically matched to the resources of the partnership, the expected duration of the partnership and its strength.

Population-level outcomes are measured by changes in the condition or well-being of a group such as children, families, or communities.   Note that changes in population level outcomes are often long-term results of the efforts of a number of different programs, agencies, and initiatives. Data on indicators for long-term outcomes are often collected by administrative agencies on an annual, bi-annual or tri-annual basis. Census data is collected every four years.

Questions to consider in developing long-term outcomes are:

- Are outcome measures aligned with program goals?
- Is data on this outcome currently being collected at national or state levels?
- Over what time-frame is data currently being collected?

Suites of indicators (or measures) for long term outcomes can be found in the core data sets in Appendix A. They should be linked to intermediate outcomes as illustrated in the Healthy Choices case-study evaluation plan (Table 3).

9.　Evaluation

An evaluation plan is about assessing how effectively programs and plans have been implemented and what has changed as a result of those plans and programs. Evaluation is concerned with a systematic approach to learning about what has or hasn't worked to create change.

Evaluation and review is an essential component of an integrated plan's life, to ensure that stated plans effectively address their objectives and respond to changing circumstances. When done well, an integrated plan is likely to fundamentally change some of the ways in which health and wellbeing, and related activities are organised in an area.

Evaluation needs to be conducted at specific points in the program to measure intermediate outcomes and long-term outcomes. Ensure those data points are included in the evaluation plan alongside the sources of data to be collected, and who is responsible.

Useful evaluation frameworks are provided in the Municipal Public Health and Wellbeing Review and Evaluation Guide. [8] The different models of evaluation should be considered to determine which is most suitable for each catchment-based project. An integrated planning and evaluation cycle will require key objectives about the strategic and operational aspects of the plan, its budgetary framework and accountability structure.

Table 2 below provides an example of an evaluation plan, including program indicators and data sources for evaluation. The long term indicator is taken from Appendix C, IEPCP Coe Indicator Set, indicator 32. The intermediate outcomes need to be developed specifically for each program plan, as demonstrated in this fictional case study.

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[8] Department of Health 2013. Tools to assist in evaluation of municipal public health and wellbeing plans, p 25. Available: https://www2.health.vic.gov.au/public-health/population-health-systems/municipal-public-health-and-wellbeing-planning

Table 2 - Example evaluation plan for 'Healthy Choices - a program to encourage staff and customers to choose healthier food and drinks at Happy Valley Council sites and venues'

Purpose of the evaluation
To assess the effectiveness of the Healthy Choices program in encouraging staff and customers to choose healthier food and drinks at Happy Valley Council sites and venues.

Stated intention of the program
To reduce the consumption of red-classified food and drinks by staff and customers, and to positively influence healthy eating habits. **Long term indicator:** Rates of total energy derived from discretionary foods (i.e. red-classified food and drinks) by children, adolescents and adults has decreased to recommended levels

Program objectives
1. Affect point of purchase sales of red-traffic light food and drinks
2. Create health-promoting workplaces for staff and customers by promoting healthy food choices.

Strategy 1 - Development of Happy Valley Council Healthy Food and Drinks policy		
Program inputs	**Intermediate indicators**	**Data sources**
Development and dissemination of healthy food and drinks policy for Council venues	• Traffic light training has reached 80% of relevant staff • 80% of staff are aware of the policy • Staff can identify the venues and actions to which the policy applies	• Staff survey measuring awareness of the policy and venues and actions to which the policy applies

Strategy 2 - Over a 1-month period, change the way Red Traffic Light food and drinks are displayed in Happy Valley council venues, so that they are out of sight of staff and customers and increase options for Green and Amber Traffic Light food and drinks		
Program inputs	**Intermediate indicators**	**Data sources**
Change the way packaged drinks and food are displayed based on the traffic light system	• Red-classified food and drinks have been removed from display (are out of sight)	• Observation of targeted venues

Ensure the availability of fresh water sources at all venues	• All Council venues have free fresh water sources available at all times	• Observation of targeted venues
Increase display of green and amber Traffic classified food and drinks and ensure they are marketed at competitive price points	• Reduction in sales of red-classified food and drinks over 1 month/6 months/12 months • Increase in sales of green and amber classified food and drinks over 1 month/6 months/12 months	• Sales figures tracked over 1 month/6 month/12 month figures for green, amber and red products

Strategy 3 – Effective healthy eating education communications		
Program inputs	**Intermediate indicators**	**Data sources**
Development of effective communications plan for healthy eating messaging across council facilities	• Staff and customers noticing healthier changes in the food and drink choices • Positive change in the purchasing habits of customers in council venues - people choosing more green and amber food and drinks than prior to the intervention. • Surveys measure positive change in the attitudes of retail food outlets in council venues. • Maintenance of steady sales figures of food and drinks over 1 month/6 months/12 months	• Survey to measure whether staff and customers have noticed healthier changes in the food and drink choices • Interviews with retail owners about attitudes towards the changes at 1 month/6 months/12 months • Surveys with customers gauging satisfaction with the changes

10. Appendix A – Framework for indicators and core data sets

As discussed in section 5, the domains for the core data set for this project are provided to assist with the understanding and presentation of the various health and wellbeing concepts that are used for planning. The indicators are organised into core data sets by domains of health and wellbeing across the lifespan.

Local plans

Local plans analysed for these indicators and core data sets include:

- The Boroondara Public Health and Wellbeing Plan 2013-2017
- Manningham's Healthy City Plan 2013-2017 Municipal Public Health and Wellbeing Plan
- Whitehorse City Council, Health and Wellbeing in Whitehorse 2013-2017, Municipal Public Health and Wellbeing Plan
- City of Monash Health and Wellbeing Partnership Plan 2013-2017 and their Access and Equity Framework 2013-2017
- Inner East Community Health Service – Integrated Health Promotion Plan 2013-2017
- Manningham Community Health Service Integrated Health Promotion Plan 2013-2017
- Whitehorse Community Health Service Integrated Health Promotion Plan 2013-2017
- Women's Health East Health Promotion Plan 2013-2017
- Inner East Primary Care Partnership Integrated Health Promotion Plan 2013-2017

NB: All of the above plans will be replaced by new plans that take effect from 2017.

Each of these plans has been searched for indicators used, and these were recorded on a spreadsheet together with their priorities which were then used to create the domains for the core data sets.

Note: Whilst the indicators used in planning by the above organisations has been expanded in the core data sets, neither the domains or the indicators are meant to be exhaustive.

Indicator set 1: Demographics

Understanding the community that organisations serve is fundamental to planning as are population projections which are made available to at least 2030. Good predictions are just that but good planning on the basis of what can be determined from indicators is even more important.

Eastern Region demographics show that in the coming decade and beyond, there will be more elderly people but also more children in secondary schools. These children have already been born. There will be more elderly people, partly because 70-80 years ago the birth rate was also rising and partly because the expectation of life has continued to increase despite the dampening effects of chronic diseases including smoking. A rise in numbers of residents aged over 65 and of the very elderly, aged over 85, is expected in many parts of the EMR.

Demographics inform planning for future housing stock, schools and transport to meet the needs of both families and for the growing numbers of older people. Planners need this information to determine where those houses will be built and the impact of employment and economic opportunities, health services, and transport needs on population change.

The most commonly used indicators for planning include:
- Population size
- Population projections
- Gender profile
- Age profile including population aged over 65 yrs and 85 yrs
- Aboriginal population
- Population born overseas
- Estimates of homelessness (primary, secondary, tertiary)
- Household types including:
    - Couples with children
    - Couples without children
    - One parent families
    - Lone person households
    - Group households
    - Other families
- Social housing units

Indicator set 2: Social gradient & socio-economic status

The social gradient in health for planning demonstrates the variance in income levels and socio-economic status of the population. Understanding and illustrating the social gradient demonstrates the likely need for services because the more favourable your social circumstances such as income or education are, the better your chance of enjoying good health and a longer life.

Each step up the socioeconomic ladder is generally associated with better health and lower levels of risk factors. A good example of the social-health gradient is tobacco smoking for which prevalence among people living in the lowest socioeconomic areas is often twice as high among people living in the highest socioeconomic areas.

In Australia, the most common tool to examine the socio-economic status of geographic areas is the Socio-Economic Index For Areas (SEIFA). SEIFA is a suite of four summary measures (indexes) that have been created from ABS Census information. SEIFA numbers are given to geographic areas from SA5 (the whole nation) to SA1 (neighbourhoods) in order to show the level of disadvantage of the area relative to the rest of Australia. SA2 represents approximates a suburb level; SA3 is the area most usually representing local government catchments.

Each index summarises a different aspect of the socio-economic conditions of people living in an area. The indexes provide more general measures of socio-economic status (low income, low educational attainment, unemployment, and dwellings without motor vehicles) than is given by measuring single indicators such as income or unemployment alone, for example. Census variables relating to the educational and occupational characteristics of communities, like the proportion of people with a higher qualification or those employed in a skilled occupation are also used.

A high SEIFA score reflects lack of disadvantage rather than high advantage. In other words, the higher an area's index value, the less disadvantaged that area is compared with other areas. For example, an area that has an Index value of 1200 is less disadvantaged than an area with an index value of 900.

It is useful in planning, to show the the relative rankings for the SA2s which make up the catchment. The indicators which make up the core data for assessing the social gradient within a planning area, and its socio-economic profile include:

- SEIFA scores by SA3 and SA2
- Household income
- Internet connections by household
- Private health insurance coverage
- Concession card holders (health care cards and pension cards)
- Number of disability support pensioners
- Female sole parent beneficiaries
- People on government benefits
- Single parent and jobless families with children < 15 yrs of age
- Unemployment/Employment
- Education

Indicator set 3: Infant years and childhood

The early years of life are thought to be the most profound in a person's life. Early childhood and the early years are one of the most important social determinants of health which intersects with other social determinants including the social gradient, housing, and education, particularly parental levels of education.

There is very strong evidence for the importance of early childhood, pointing to the need for investment in early childhood services. Early intervention is one of the most cost-effective investments in social development that can be made. There is plenty of evidence to show that the most cost-effective mix of early childhood interventions includes universal high quality, low-cost pre-school and early primary school education, timely early intervention services for children showing developmental delay, as well as intensive, multi-faceted support for families with complex needs.

The pre-pubescent years – critical for healthy growth and development. Children in the primary school years are searching for their identity and are vulnerable to risk-taking behaviours.

Nutrition is one of the most important factors affecting pubertal development. There is emerging evidence that obesity can accelerate the onset of puberty in girls and may delay the onset of puberty in boys (ref). Eating disorders also begin to emerge in this period of childhood.

Housing and child health are also connected. For children's social and emotional outcomes, the family aspects of a home and parenting styles and capacities are of greater relative importance than physical properties of the buildings. Other aspects of housing likely to impact on children's social and emotional wellbeing include frequent moves, renting rather than owning and being in financial stress. In these ways, the early years are connected to the socio-economic gradient and to liveability indicators.

Neighbourhood effects are more important than characteristics of individual dwellings in promoting the wellbeing of children, particularly once they pass toddlerhood. That means that urban planning must concentrate on features such as all-ability and accessible parks and playgrounds and other open areas because they are conducive to children's development and wellbeing. These amenities are particularly important in areas where there is a concentration of families receiving housing assistance and areas with public housing residents. Creating and building neighbourhood amenity is therefore, an important role for local governments in creating communities for children.

The Australian Early Development Index (AEDI) is a population measure of children's development as they enter school, and is a reliable measure of how young children are developing in different communities. Based on the scores from a teacher-completed checklist, the AEDI measures five areas, or domains, of early childhood development:

1. Physical health and wellbeing
2. Social competence
3. Emotional maturity
4. Language and cognitive skills (school-based)
5. Communication skills and general knowledge.

The indicators which make up the core data for assessing the quality of the early years and childhood in a planning catchment include:

- Australian Early Development Census (AEDC) key indicators (children developmentally vulnerable on one or more domains)
- Life expectancy at birth
- Rates of mothers smoking during pregnancy
- Birth weight and antenatal care
- Children who participate in key ages and stages visits to 12 months/36 months
- Child protection reports
- Immunisation rates
- Rates of breastfeeding
- Decayed-missing-filled teeth in children 0-5 yrs
- Children meeting daily guidelines for sufficient physical activity
- All-ability and accessible playgrounds and open spaces
- Children eating recommended daily serves of fruit and vegetables
- Child nutrition – total energy from discretionary foods (soft drinks, cordial, energy drinks, snacks)
- Children learning about mental health
- Children learning about Respectful Relationships
- Bullying
- Participation in sport
- Percentage of primary schools teaching Kids Matter curriculum
- Percentage of primary schools teaching Respectful Relationships curriculum
- Consumption of sugary drinks
- Children meeting daily guidelines for sufficient physical activity
- Children who eat the minimum recommended serves of fruit and vegetable every day
- Children who report bullying

Indicator Set 4: Adolescence – 13-24 years

Planning for health and wellbeing requires local level information on the health, wellbeing, learning, safety and development of adolescents. It is particularly important to identify the numbers of vulnerable young people and families, and the services they need to assist them to reach their goals and aspirations.

The Victorian Child and Adolescent Monitoring System is a very good source of data about young people. It is a comprehensive, across-government monitoring system that reports on the safety, health, development, learning and wellbeing of children and young people, aged 0 to 17 in Victoria. It is intended to underpin planning for improvement at a program, local government and statewide level, as well as to inform research and evaluation to generate new evidence on effectiveness on improving outcomes for children.

The indicators which make up the core data for assessing the quality of the young people and adolescents include:

- Young people who report bullying
- Percentage of schools which teach Mental Health Matters
- Adolescent smoking rates
- Sexual activity in young adolescents
- Percentage of sexually active adolescents reporting they used a condom
- Incidence of STIs
- Young people attending school at age 16 yrs
- Young people perceiving schools as unsafe for same-sex attracted young people
- Percentage of students attending government school
- Percentage of Year 9 students who attain national minimum standards in reading
- Percentage of Year 9 students who attain national minimum standards in writing
- Young people aged 19 years who have attained Year 12 or equivalent
- 16-24 yrs olds described as NEET (Not in Education, Employment or Training)
- Young people meeting guidelines for sufficient physical activity
- Young people who eat the minimum recommended serves of fruit and vegetable every day (DEECD)
- Rate of intentional self-harm among young people
- Young people with an eating disorder
- Youth offending

Indicator Set 5: Ageing

Ageing is a biological and social process, strongly affected by socio-economic factors. The Inner East catchment has among the highest rates of ageing people in Victoria. The service demands that arise from such a rapidly growing older age group are varied, but will only increase in coming years. It is therefore. important to monitor the ageing profile of the catchment, in order to plan, coordinate and deliver appropriate services.

Health and wellbeing in people's older years is affected by a range of factors including their support networks, proximity to family, the existence of multi-generational households, an increasingly long life span between retirement and death and the prevalence of chronic diseases among older people because they are living longer.

Some of the aims of healthy ageing programs are to maximise the quality of life of older people including maximising their contribution to society, and minimizing the costs of health and social care.

In order to plan for healthy ageing programs or service needs assessment for older people, it is necessary to understand the places in the catchment where older people live in greater proportions than other areas, and where the highest rates of poverty among people exist.

The indicators which make up the core data for assessing ageing include:

- Age profile (median, notable differences compared to Greater Melbourne)
- People over 65 born overseas
- Numbers of Aboriginal people aged over 65 years
- Population projections
- Aged and disability characteristics including:
    - Percentage of older people with need for assistance with core activities
    - Percentage with severe and profound disability living in community Percentage of persons aged 75 years+ who live alone
    - Disability support pension recipients per 1,000 eligible population
    - Age pension recipients per 1,000 eligible population
- Percentage of older people engaged in volunteering
- Age-standardised incidence and prevalence of diabetes in persons aged over 65 years
- Prevalence of dementia
- Public dental service waiting lists for dentures, denture repairs
- Access to services for older people

Indicator Set 6: Health Status

Local governments have legislative authority and community responsibility based on an electoral mandate to plan for local areas and ensure community health, wellbeing and development. Local governments have key roles in prevention through immunisation, health inspections and creating healthy environments. Community Health Services are primarily funded to provide primary health care services including dental care and health promotion. Women's Health Services are almost entirely funded for health promotion in relation to women's health.

The function of a Council under the Public Health and Wellbeing Act is to seek to protect, improve and promote public health and wellbeing within the municipal district by:
- Creating an environment which supports the health of members of the local community and strengthens the capacity of the community and individuals to achieve better health;
- Initiating, supporting and managing public health planning processes at the local government level;
- Developing and implementing public health policies and programs within the municipal district;
- Developing and enforcing up-to-date public health standards and intervening if the health of people within the municipal district is affected;
- Facilitating and supporting local agencies whose work has an impact on public health and wellbeing to improve public health and wellbeing in the local community;
- Co-ordinating and providing immunisation services to children living or being educated within the municipal district;
- Ensuring that the municipal district is maintained in a clean and sanitary condition.

Health status may be measured by factors such as the prevalence of disease, the impact of disability, mortality, mental health and social wellbeing. These measures provide information about the health profile of a given population, including any inequities and suggest possible intervention opportunities. Chronic diseases such as heart disease, stroke, cancer, chronic respiratory diseases and diabetes, are leading causes of death and disability in Australia[9]. Reducing risky health behaviours particularly tobacco smoking, excess weight, physical inactivity and poor diet, can prevent many chronic diseases.

Access to GPs is key consideration for health planning, because when people have difficulty accessing the primary health services they need, such as an appointment with a GP, they may choose to attend an emergency department or delay seeking care until their condition worsens to the point where they need to go to hospital.

Ambulatory Care Sensitive Conditions (ACSCs) are health conditions where good primary health care can potentially prevent the need for hospitalisation, or where early intervention can prevent complications or more severe disease. Chronic ACSCs are selected chronic conditions, such as diabetes, that can be managed by primary care providers to prevent the condition worsening and requiring people to attend hospital. Acute ACSCs are acute diseases or conditions, such as a kidney infection or dental condition, that may not be preventable but

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[9] Australian Institute of Health and Welfare (2006). Webpage Chronic diseases and associated risk factors in Australia

the person may not have to attend hospital to treat the condition if there is access to adequate primary care services.

The following list of indicators makes up the core data for assessing the health status of communities in the Inner East region:

- Access to GPs
- Population with private health insurance
- Self-reported health status
- Aged and disability characteristics
- Obesity
- Diabetes and asthma incidence and admissions
- Cancer diagnoses
- Infectious diseases
- Ambulatory care sensitive conditions
- Physical activity
- Dementia
- Alcohol and tobacco use
- Hospital admissions to A&E with an alcohol related diagnoses
- Hospital separation for alcohol intoxication, withdrawal or dependence
- Short term harm from hospital consumption
- Alcohol and/or marijuana use in adolescents
- Rate of mothers smoking in pregnancy
- Population smoking rates
- Support for smoking ban in outside seating areas
- Children living in households with current or daily smoker

Indicator Set 7: Food Security and Healthy Eating

Food and nutrition have long been recognised as important contributors to health. However, food and nutrition affect more than just the physical aspects of our health and wellbeing. The buying, preparing and eating of food is part of everyday life. For many Australians, food is a focus for social interactions with family and friends. Food security is broadly defined as "access by all people at all times to enough food for an active, healthy life" (Radimer, 2002).

Community Indicators Victoria indicators seek to identify people who may be at risk of a poor diet and nutrition. These risks may be due to their financial incapacity to purchase food, or lack of easy access to affordable food. Food insecurity is linked to the social determinant of social exclusion. Food insecurity exists "whenever the availability of nutritionally adequate and safe foods or the ability to acquire acceptable food in socially acceptable ways is limited or uncertain".[10]

The World Health Organization identifies three key elements of food security[11]:

> 1. Food access: the capacity to acquire and consume a nutritious diet, including:
> – the ability to buy and transport food;
> – home storage, preparation and cooking facilities;
> – knowledge and skills to make appropriate choices; and
> – time and mobility to shop for and prepare food.
> 2. Food availability: the supply of food within a community affecting food security of individuals, households or an entire population, specifically:
> – location of food outlets;
> – availability of food within stores; and
> – price, quality and variety of available food.
> 3. Food use: the appropriate use of food based on knowledge of basic nutrition and care.[12]

The indicators which make up the core data for assessing food security and food insecurity include:

- The percentage of people meeting the recommended consumption of 2 serves of fruit per day (CIV and VPHS)
- Sharing a meal with family on five or more days/week
- The percentage of the adult population consuming the recommended intake of 3 serves of vegetables per day (CIV and VPHS)
- Percentage of children consuming the recommended serves of vegetables per day
- Percentage of children consuming the recommended services of fruit per day
- People who ran out of food in the last 12 months and could not afford to buy more (CIV)
- Costs of healthy food basket across local neighbourhoods
- Percentage of neighbourhoods classified as food desert.

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[10] Radimer, 2002
[11] World Health Organisation, 2011
[12] CAFCA 2011

Indicator Set 8: Gender Equity

Gender is a determinant of health that accounts for the fundamental differences between women's and men's experience of health issues, and of the health system. Gender is part of a social system that determines roles hierarchically and that is infused with values and norms.

A gender lens can be used to examine any set of indicators, and is used in planning to promote equity between women and men in policies, programs and services, employment opportunities and other areas.

Social and economic status is in part about the social gradient, as well as degrees of power and empowerment (people's sense of control over their lives), access to resources and income security, and social support. Gender particularly interacts with socio-economic circumstances. Women experience lower levels of income across their lifespan, and relatively subordinate positions of power and lower levels of decision-making power, whether in political arenas, workplaces or within families.

In determining health and illness outcomes, health systems have a responsibility to acknowledge the importance of gendered social relations, social factors, and conditions of living. While women live longer than men, women experience a range of issues which can cause distress and poor health including reproduction, higher burdens of childcare, care of disabled and older family members, intimate partner violence and other risks to personal safety, insecure employment, lower earnings over a lifetime, and poor mental health.

Violence against women (or family violence/Intimate Partner Violence) is a gender based crime. It is an insidious violation of human rights with serious impacts on the health and wellbeing of those affected. The cost to Australia's economic and social fabric was estimated at $21.6 billion in 2014 (PwC/VicHealth). On average in Australia, every 3 hours a woman is hospitalised and every week a woman dies from partner violence.

Sexual and reproductive health (SRH) is one of the priority areas for Women's Health East in their 2014-2017 Integrated Health Promotion Plan. They have conducted a regional needs analysis around the SRH of women in the Eastern Metropolitan Region (EMR). This analysis was undertaken in 2014 and 2015 and included a literature review, data collection, and consultations with a range of organisations both within the region and at state level. Using a population health approach, women who are more likely to face complex barriers to good SRH were identified. The associated priority needs of these groups were explored and recommendations were made regarding each of these priorities.[13]

The EMR is home to a diverse range of women. These women are of all ages and may be Aboriginal; from a variety of ethnic, cultural and language backgrounds; live in a range of social and economic circumstances; of diverse sexuality and gender identity; have a range of abilities; have attained different levels of education; and participate in varying degrees and types of employment.

Analysis of the evidence, demographic data and consultation findings revealed that women in the EMR who were most likely to experience SRH inequities included young women, those from migrant, newly arrived and culturally diverse backgrounds, Aboriginal women, those

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[13] Women's Health East (2015) 'Eastern Metropolitan Region Sexual and Reproductive Health Needs Analysis'

who have experienced violence from men, women with disabilities and women of diverse sexuality and gender identities.

The associated priority needs were identified as follows:

1. Representation of SRH issues in Regional Policy and Planning
2. Sexually transmitted infections
3. Reproductive empowerment, access and rights
4. Sexualisation and objectification of women
5. Sexual and reproductive health literacy
6. Female Genital Mutilation/Cutting

The indicators which make up the core data for assessing gender equity include:

- Sexual and reproductive health
- Sexual activity in adolescents
- Breast cancer screening
- Cervical cancer screening
- Incidence of STIs
- Violence against women
- Women's participation in the workforce
- One-parent families with children under 15 years were headed by women
- Young people learning about Respectful Relationships
- Children in out of home care
- Incidence of family violence
- Women seeking emergency housing or shelter due to family violence
- Community attitudes towards violence against women
- Experience of violence in the preceeding 12 months
- Percentage of female councillors

Indicator Set 9: Improving Mental Health

Good mental health is integral to human health and wellbeing. People's mental health and many common mental disorders are shaped by various social, economic, and physical environments operating at different stages of life. Ensuring communities and populations have the opportunity for good mental health and wellbeing requires work across individual, community, organisational and societal levels[14].

The determinants of poor mental health include all forms of discrimination, violence and lack of safety, poverty and unemployment, poor employment conditions, lack of access to education and needed health services, and lack of support. The broad determinant of access to economic resources (and thus economic participation) is strongly correlated with mental health at all life stages.

Determinants which create good mental health in the population lie within the social and economic domains of our lives, and include social inclusion, having a valued social position, physical and psychological security, opportunity for self-determination and control over one's life and access to meaningful employment, education, income and housing[15]. Mental health is connected to Work, education, appropriate housing and sufficient money to live both protect and promote mental health and wellbeing.

Good mental health among the population is heavily reliant on efforts to improve the conditions of everyday life. Taking a life-course approach, the foundations for good mental health begin before birth and progresses into early childhood, older childhood and adolescence, during family building and the working years, through to older age. Planning for each of these life stages provides opportunities for both improving population mental health, and reducing risk of those mental disorders that are associated with social inequalities.[16] Population mental health is also measured by people's level of civic trust, their levels of participation in civil society, and levels of volunteering.

Mental health illnesses or conditions can vary in both severity and duration, and are on a spectrum. The most common mental disorders are depression, anxiety and substance use disorders for which early intervention services and programs are critical. Mental health problems that are first identified in adolescence and adulthood, including debilitating depression, anxiety disorders and drug misuse, can have their origins in pathways that begin much earlier in life with childhood mental health problems.[17]

Less common, and often more severe disorders include schizophrenia, schizoaffective disorder and bipolar disorder. Mental health disorders are commonly associated with substance use disorders, creating what is called a dual disability. The National Mental Health Report 2013 estimated that 2–3% of Australians, or around 600,000 people, have severe disorders, as judged by diagnosis, intensity and duration of symptoms, and degree of disability including people with severe and disabling forms of depression and anxiety.

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[14] Keleher, H & Armstrong, R 2005, *Evidence-based mental health promotion resource*, Report for the Department of Human Services and VicHealth, Melbourne.

[15] ibid

[16] World Health Organization 2014. Social determinants of mental health.
http://www.who.int/mental_health/publications/gulbenkian_paper_social_determinants_of_mental_health/en/

[17] Bayer J Beatson R. 2013. Early intervention and prevention of anxiety and depression. Murdoch Children's Research Institute, Melbourne. Available: http://www.child-encyclopedia.com/anxiety-and-depression/according-experts/early-intervention-and-prevention-anxiety-and-depression

People with psychotic disorders represent about one-third of those with severe mental illness. For severe mental disorders, 0.45% of the population aged 18–64, almost 64,000 people or just 1/3rd of the 200,000 who have a psychotic disorder, were treated annually by public sector mental health services, with schizophrenia being the most common disorder. Another 4–6% of the population (about 1 million people), have moderate mental health conditions, and a further 9–12% (about 2 million people) have a mild mental health condition.[18]

The indicators which make up the core data for assessing mental health for planning purposes include:

- Estimates of population experiencing severe disabling mental health disorders
- Deaths from suicide and self-harm injuries
- Intentional self-harm
- Percentage of primary schools teaching Kids Matter curriculum
- Percentage of secondary schools teaching Mind Matters curriculum
- People reporting experiencing psychological distress
- Rates of psychiatric hospitalisation and intentional self-harm
- Adolescents with a trusted adult in their life
- Unmet needs relating to mental illness
- Deaths from suicide and self-harm injuries
- Volunteerism and community participation/engagement
- Society and civic trust (adults feeling valued by society)
- Work life balance
- Mental illness and distress

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[18] AIHW 2014. Australia's Health 2014.

Indicator Set 10: Housing and Homelessness

Shelter is a pre-requisite of health. Access to adequate housing is a key determinant of health. Homelessness is therefore, significantly related to health outcomes. Affordable, appropriate, and adequate housing has a marked impact on people's health, their access to labour markets, and many other benefits. Planning partnerships between local governments and other agencies are important to achieve targeted investment to ensure adequate affordable housing stock.

Housing affordability is increasingly of concern in urban Melbourne, with housing and mortgage stress resulting from the costs of private housing. A family or individual is considered to be in mortgage stress if they are in a low-income bracket and pay more than 30% of their income on mortgage repayments. Acute mortgage stress occurs when 50% of income is spent on mortgage repayments. Increasing numbers of families are experiencing housing stress, and are at risk of homelessness. Further, poor housing is frequently associated with poorer health[19]. Mortgage and housing stress can lead to family conflict and breakdown.

Homelessness can happen for a number of reasons, including family violence, financial stress, and the cots of housing. Homelessness numbers are difficult to count. Undercounting is likely because of the transient nature of homelessness and the difficulty of counting people who are sleeping rough or 'sofa-surfing'. Risks for homelessness are tied to indicators about the numbers of people on very low incomes: people on very low incomes who cannot make ends meet will find themselves homeless, including older people living on pensions in the private rental market who are vulnerable to precarious housing situations.

Domestic violence is one of the typical pathways into homelessness for Australian women. Women seeking emergency housing frequently have responsibilities for children.

Across Victoria, homeless men outnumber homeless women by 55 to 45 per cent but there were more females in the 12-18 age group and roughly equal numbers of males and females in the 19-24 and under-12 age groups. However, from age 25 onwards men typically outnumber women, about 60 per cent to 40 per cent.

The indicators which make up the core data for assessing housing and homelessness include:

- Housing affordability
- Housing diversity
- Mortgage stress
- Homelessness numbers (ABS Census and Centrelink)
- Women seeking emergency housing
- Women with children under 12 yrs seeking emergency housing
- Social housing

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[19] Social Determinants of Health: Housing Fact Sheet. https://www.health.qld.gov.au/ph/Documents/saphs/20398.pdf

Indicator Set 11: Liveable Neighbourhoods

Community Indicators Victoria have been working on indicators aligned to the social determinants of health, providing useful measures for investigating the liveability of an area and how this impacts on the wellbeing of its residents (Living in Boroondara 2015). These indicators have been derived based on spatial, survey and administrative data sources and have been developed based on previous research that has demonstrated the importance of social, economic, cultural, democratic, built and natural environment factors that influence health outcomes. We understand the importance of considering how the environment impacts health outcomes and will review these indicators in the core dataset listed below.

Perspectives and definitions of liveability vary widely and very dependent on the lens used to consider what makes a neighbourhood a good place to live. Liveability is the sum of factors that comprise a community's quality of life. Those factors include the built and natural environments, economic prosperity, social equity, education and employment opportunities, cultural, entertainment and recreation facilities. A liveable neighbourhood is also be defined as one that provides good access to health services, education, mobility options, fresh food options.

There are many conceptual lens through which to see what makes a neighbourhood more or less liveable, but not have established measures in available data sets. Rather, they could be explored by community consultations including:

- Community identity
- Sustainable urban development
- Infrastructure for walking, cycling and public transport
- Density
- Accessible public open green spaces
- Heritage protections
- Affordable housing

Public health and wellbeing planning has key responsibilities for liveability. Indicators available for what comprises a liveable neighbourhood include:

- Distance to public open space
- Playgrounds and open spaces
- Public transport
- Walkability
- Food access
- Gambling on EGMs
- Crime
- Internet access
- Access to GPs
- Access to services for older people
- Perception of safety

11. Appendix B – IAP2 Spectrum of Public Participation

	Inform	Consult	Involve	Collaborate	Empower
Public participation goal	To provide the public with balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/ or solutions	To obtain public feedback on analysis, alternatives and/or decisions	To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered	To partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solutions	To place final decision-making in the hands of the public
Promise to the public	We will keep you informed	We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how public input influenced the decision	We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influenced the decision	We will look to you for advice and innovation in formulating solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible	We will implement what you decide
Example techniques	Fact Sheets Websites Open houses	Public comment Focus groups Surveys Public meetings	Workshops Deliberative polling	Citizen advisory committees Consensus – building Participatory decision-making	Citizen juries Ballots Delegated decisions