Report on the Workshop
Using the evidence to build a catchment response to the primary health needs in Frankston and Mornington Peninsula

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Introduction

This report sets out a summary of the discussions and priorities developed at the Frankston and Mornington Peninsula Planning Workshop held on 3rd June 2015 at the Peninsula Community Theatre in Mornington. The workshop was co-hosted by the Frankston Mornington Peninsula Medicare Local (FMPML) and the Frankston Mornington Peninsula Primary Care Partnership (FMPPCP). A copy of the agenda can be found in Appendix 1 of this report.

The workshop was attended by representatives from a broad range of member agencies (see appendix 2) and facilitated by Juliet Frizzell.

Workshop Overview

The purpose of the workshop was to:

- Hear about the changing policy environment and reform agenda.
- Learn about the strategic directions of key stakeholders, including Peninsula Health, local government and the new South Eastern Melbourne Primary Health Network (SEMPHN).
- Celebrate the achievements of the Peninsula Model Alliances.
- Utilise the FMPML's population health data and the Conceptual Framework for Local Collaboration to identify the primary health priorities for the Frankston Mornington Peninsula catchment.
- Undertake initial planning to progress the catchment's priorities.

The sessions before lunch provided the context for discussions on priorities for the catchment, which were held after lunch. The speakers were:

- *Terry Palioportas*, CEO Peninsula Support Services and Chair of the Peninsula Model Governance Group and the FMPPCP. Terry set the context for the workshop, and spoke about the role of partnerships, the importance of population health planning and how collective effort would achieve the greatest impact for the community.
- *Mary Sayers*, Deputy Chief Executive Officer VCOSS. Mary spoke about the reform environment and what it means for the Frankston and Mornington Peninsula catchment (A copy of Mary's presentation can be found in Appendix 3).
- *Christine Roughead*, Director KPMG Australia. Christine presented on the 'Integration Imperative' and provided examples of what is happening globally,

including projects focusing on inter-governmental integration, inter-sectorial integration and place-based integration (A copy of Christine's presentation can be found in Appendix 4).

- *Simon Faivel,* Director Social Ventures Australia (SVA) Consulting. Simon spoke about how the Collective Impact Framework, can measure impact, outcomes, value for money and change (A copy of Simon's presentation can be found in Appendix 5).
- *Ruth Azzopardi*, General Manager Community Health at Peninsula Health. Ruth outlined the population health approach being used by Peninsula Health to set the strategic directions for Community Health (A copy of Ruth's presentation can be found in Appendix 6).
- *Dean Tillotson*, Interim CEO South Eastern Melbourne Primary Health Network. Dean provided an update on the establishment of the new PHN and highlighted some of the data drivers that SEMPHN will be using to set its priorities (A copy of Dean's presentation can be found in Appendix 7).
- *Josephine Beer*, Relationship Manager, Innovation Projects Innovation Hub and Health System Improvement at DHHS. Josephine talked about the Department's Accountable Care Model for measuring patient outcomes (A copy of Josephine's presentation can be found in Appendix 8).
- *Rod Mackintosh*, Executive Director Service Development FMPML. Rod outlined some of the achievements and successes of the Peninsula Model and the Alliances, and spoke about the challenges and opportunities moving forward (A copy of Rod's presentation can be found in Appendix 9).

Population Health Data: Evidence for Action in the Frankston Mornington Peninsula Catchment

Professor Helen Keleher, Managing Director Keleher Consulting, concluded the morning session by presenting an overview of the population health data and evidence for action. Helen's key message was "*more of the same is not good enough*". Helen noted that the key issues for the catchment were:

- Vulnerable children – vulnerable youth
- Violence against women and children
- Mental health
- Aboriginal health
- Chronic disease
- Drug and alcohol misuse
- Health literacy
- Access to health services

She also noted that moving forward 'creating health and reducing health inequalities' will require non-government organisations and governments (State and Local) working together in partnership.

A summary of the evidence presented by Helen is set out in the table below, and a copy of her presentation can be found in Appendix 10.

The Peninsula Model for primary health planning

Keleher Consulting

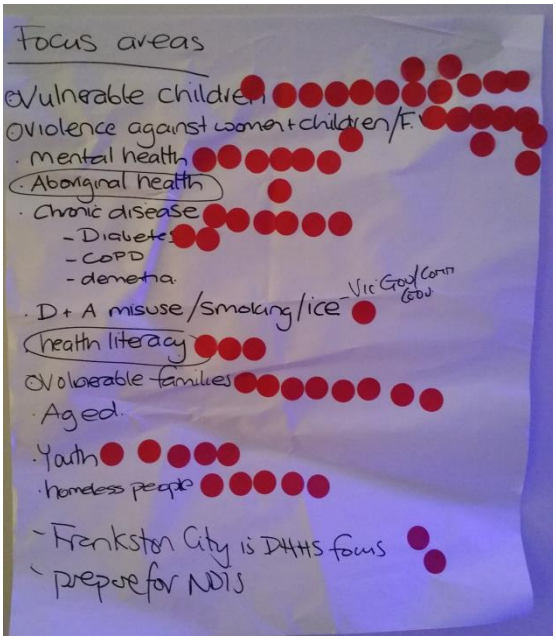
EVIDENCE SUMMARY

LOW SOCIO-ECONOMIC STATUS		WOMEN, CHILDREN, YOUTH		DEMOGRAPHICS		INFRASTRUCTURE	
EVIDENCE	IMPACT	EVIDENCE	IMPACT	EVIDENCE	IMPACT	EVIDENCE	IMPACT
• Distinct communities living with high levels of disadvantage, social housing, rooming houses and homelessness • Mental Health – priority of all three MLs in the SMR and all PCPs • Smoking rates significantly higher than Vic average across much of the F-MP catchment • High levels of poor nutrition and overweight/obesity • Poor health literacy • Child protection rates per 1000: Frankston 6.9 MPS 4.8 Victoria 4.4	• High rates of children developmentally vulnerable on AEDC in those communities • Frankston has the highest number of Primary Homeless people in the SMR. • Demand for services, insufficient service delivery • Rates of COPD and lung cancer 3rd highest in Victoria • Type 2 Diabetes rates in Rosebud (8.2%) and Frankston (7.4%) -- significantly higher than Vic average (4.5%)	• Frankston LGA has 3rd highest rate of violence against women • Pervasive social culture of gender inequity • Demand for emergency housing • Lack of specialist Children's Mental Health services in F-MP catchment • 20% of homeless people are 12-19 yrs • Psychiatric hospitalisations for youth in Frankston 9.3/1000 people (Vic 6.7 per 1000)	• Greatest impact is on women's mental health • Demand for emergency housing exceeds supply • Children's exposure to violence causes behavioural issues and problems with learning • Troubled children become troubled youth • Troubled youth become troubled adults	• MPS has highest ageing population in Greater Melbourne • 6000+ children < 15 yrs live in jobless families (Frankston 15%-Vic 12.7%) • Frankston and MPS have highest proportion of Aboriginal people in the SMR.	• Rates of dementia increasing • Rates in Frankston of young people not 'Learning or Earning' lowest in SMR • Poor health literacy • Numbers of Aboriginal people are increasing • A greater proportion are aged 25 yrs or younger than the non-Indigenous population	• Poor public transport access • Poor access by some groups to effective primary health care • Insufficient early childhood screening for developmental delay • Insufficient access to timely interventions for developmental delay especially for vulnerable children in disadvantaged communities	• Costs to people and the health system • Diminished quality of life • Too many diabetics in hospital beds • Poorly managed chronic disease • High rates of avoidable hospitalisations

Identifying Priorities for the Frankston Mornington Peninsula Catchment and the Peninsula Model

Reflecting on the morning's presentations[1] and the Evidence Summary provided by Professor Keleher, the participants identified the following priorities for action under the Peninsula Model[2].

- Vulnerable children and families
- Family violence, particularly violence against women and children
- Mental health
- Chronic disease / aged
- Youth
- Homelessness[3]



It was agreed that Aboriginal health, health literacy. Homelessness and disability went across all the above priorities.

Unpacking the Priorities

Using the Conceptual Framework for Medicare Local Collaboration 2013 (see below), small groups supported by a Facilitator worked through the following questions.

1. What does your focus area's pathway or system look like and how is the pathway or system performing?
2. What are the main issues along your chosen pathway or system?
3. What are the root causes which underlie the identified issues?
4. What is likely to happen if we do nothing?
5. Who are the relevant stakeholders (clients, government, service providers, and local government) and what are their underlying motivations?
6. What is the case for change and next steps?

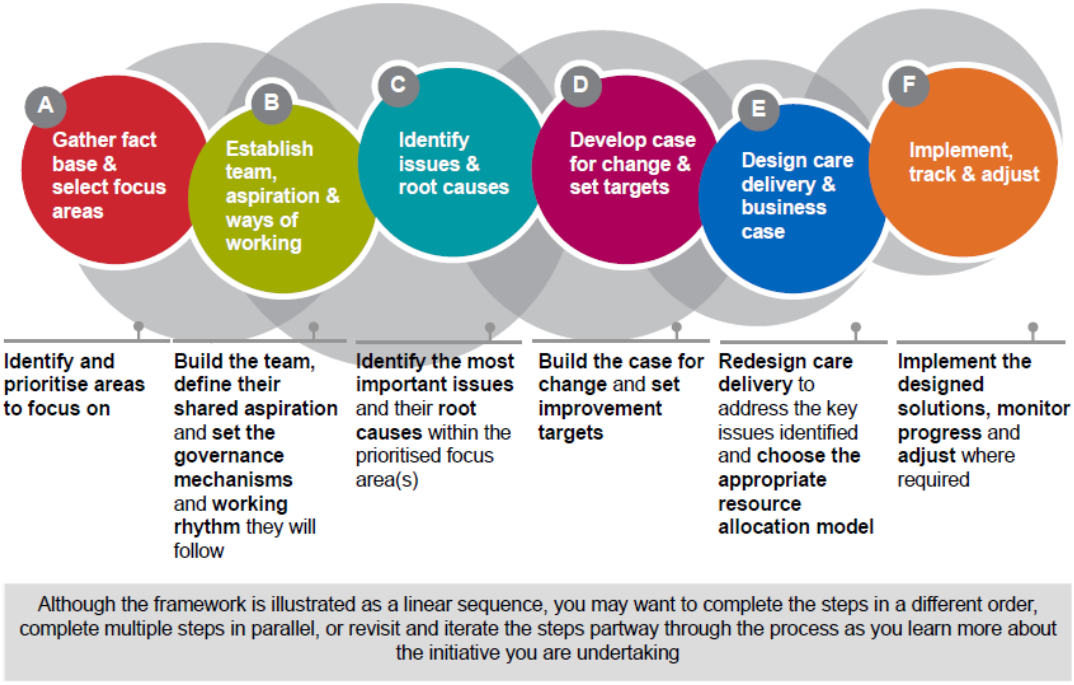
Key themes from the small group discussions were:

- Prevention and early intervention is not being done well enough across all priority areas.
- There are opportunities to improve connectivity and integration across the client journey (prevention, early intervention, service coordination, complex care and transition/exit).

[1] Policy and reform themes impacting on the catchment: restructuring and recommissioning; fiscal restraint, value for money and investment; outcomes focused; technology and e-health; flagships for change – place-based, client directed, codesign, integration, inter-sectorial; systems change rather than project based; data and evidence driven; reform – aged care, MBS, NDIS and PHNs; collaboration and partnership; innovation rather than business as usual; and broadening partners – police, education, employment providers.
[2] This list was prioritised from a large list which included: Vulnerable children and families; Family violence, particularly violence against women and children; Mental health; Chronic disease (diabetes, COPD and dementia); aged; Youth; Homelessness; Aboriginal health; drug and alcohol misuse/smoking/ice; health literacy; vulnerable families; Frankston City; preparing for the NDIS; disability.
[3] The list was developed from the larger list (above), using the following criteria: where we can have an impact and achieve real outcomes; there are limited resources, so we can only work on some things; where there are KPIs for evaluation; where we can achieve value for money; support integration; where we can collaborate around existing investment; where we can get buy-in from local government and the broader partnership group – police, education, employment etc; where we can affect change; should link with individual agencies priorities; hots spots.

- Current investment could be more effectively spent to achieve value for money and impact.
- There is a commitment to work in partnership to improve the service system and affect change for the community.

The six steps to establishing effective collaboration across local health communities



Although the framework is illustrated as a linear sequence, you may want to complete the steps in a different order, complete multiple steps in parallel, or revisit and iterate the steps partway through the process as you learn more about the initiative you are undertaking

Small group discussions: Butchers Paper

<table>
<tr><th colspan="2">Vulnerable children and families / Family violence, particularly violence against women and children</th></tr>
<tr><td>1. What does your focus area's pathway or system look like and how is the pathway or system performing?
2. What are the main issues along your chosen pathway or system?
3. What are the root causes which underlie the identified issues?</td><td>4. What is likely to happen if we do nothing?
5. Who are the relevant stakeholders (clients, government, service providers, and local government) and what are their underlying motivations?
6. What is the case for change and next steps?</td></tr>
<tr><td>Prevention
Lack of services
Lack of education
Lack of trauma informed practice
Lack of funding for programs like Kids Matter and Mind Matters
Early intervention
Lots of things in place but siloed e.g. MCH Nurse screening for DV, KESOs
RACGP accreditation system to encourage GPs
Lack of outreach services
Service Coordination
Service pathways need to be promoted more
Health literacy – visual documents needed
Knowledge of FV amongst professionals is poor
Lack of joint planning with education, health, FV services, police, AOD, consumers
No colocation of services
Transition and exit
No GP contact at services
MCH Nurse is critical point
More outreach services are needed, including GPs
Reconnection points and options for families that disengage are needed
Lack of discharge planning and processes
Needs to be more client focused</td><td>What needs to be done?
Family Services App – and support plan for agency implementation
Advocate for Kids Matter and Mind Matter in all schools
SSSO and KM Project Officer to deliver professional development in agencies
Advocate for sustainability of programs
Antenatal education and communication
Increase universal screening for FV
Outreach component including Aboriginal health
Promotion of referral pathways as per the Map of Medicines
Joint planning
Stakeholders:
Education
Health
Early childhood services
Police
AOD
DHS CP
OOHC
Consumers
Community consultant
Small business
KESOs
Case for Change
Service system redevelopment for proactive engagement with families including colocation of services and discharge planning with reconnection points for families and children
Trial models of GP engagement with clinical services – as per the Tassie model and Doveton College</td></tr>
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Chronic disease / aged	
1. What does your focus area's pathway or system look like and how is the pathway or system performing? 2. What are the main issues along your chosen pathway or system? 3. What are the root causes which underlie the identified issues?	4. What is likely to happen if we do nothing? 5. Who are the relevant stakeholders (clients, government, service providers, and local government) and what are their underlying motivations? 6. What is the case for change and next steps?
Prevention • Health literacy – understanding their conditions • Navigation of the service system • Healthy Lifestyles – diet and exercise • Environment – green space, access to healthy food • Advocacy • Targeted communities Early intervention • risk identification • Early referral and information e.g. Pre diabetic programs • Risk factors – suggest interventions Service coordination • Multiple services and providers – poor performance • Need tools to coordinate care • Funding needed to encourage service coordination • Lack of awareness of services • Push back when others want to coordinate – need to build trust • Lack of connected systems and information • Learn from Carepoint • Leverage off existing programs – secure messaging Complex care • HARP - good • Carepoint – Okay • The rest – nothing Transition • Support at home or RACF • HACC home care packages • Need tailored transition Root causes • Hard to engage people when they are not unwell yet, as they have other priorities • Long time before outcomes are realised • Big gap between diagnosis and intervention – don't know, don't care, no time (Carepoint may be a solution) • Service coordination issues relate to knowledge, funding constraints, systems that don't talk, poor coordination at all levels	If we do nothing • Poor outcomes Stakeholders: • Funders (DHHS, Commonwealth and LGA's Wellbeing Plans) • Legislators • Clinicians • Consumers • Peak bodies Next Steps • Engagement with Carepoint and other working models i.e. BSL pilots • Secure messaging • Map of medicines – promote and expand • Align with existing projects • Advocate to connect systems e.g. My Aged Care, PCEHR, NDIS • Ensure prevention is a priority • Work and advocate across alliances

Mental health	
1. What does your focus area's pathway or system look like and how is the pathway or system performing? 2. What are the main issues along your chosen pathway or system? 3. What are the root causes which underlie the identified issues?	4. What is likely to happen if we do nothing? 5. Who are the relevant stakeholders (clients, government, service providers, and local government) and what are their underlying motivations? 6. What is the case for change and next steps?
Pathway / systems issues at prevention, early intervention, service coordination and complex care: • Lack of screening and early identification • Screening needs to start at ante-natal care • Social connectedness • Ageing population – what is being done? • Early intervention is ad hoc • Treatment is disjointed • Service continuum does not come together • Only a few integrated models, such as breaking the cycle • There are problems with the transition and exit • Skill gaps • Gaps in support and services for carers • Peer workers needs further development and support	If we do nothing: • No new capacity • Revolving door • Siloed services • More vulnerable children Changes: • Capacity building • Greater knowledge of referral pathways • Access to secondary consultation • Greater integration of clinical, MHCSS and other domains • Multi-disciplinary approach • Multi-sectorial approach – housing, AOD, primary health, family violence, acute mental health, primary secondary and tertiary education • Look at colocation options (Rooming houses) • Evidence-based integrated models Stakeholders: • General practice • Schools • Police • Mental health services and professionals • Child Protection • Centrelink • Residential Aged Care Facilities Next Steps: • Universal screening to identify people at-risk implemented across primary health, community services, government services and education • Integration of current services with innovative models to meet multiple needs (look at DDx program through AoD Alliance) • Investigate innovative funding opportunities for early intervention programs i.e. social connectedness (AOD and MH Alliances)

Youth	
1. What does your focus area's pathway or system look like and how is the pathway or system performing? 2. What are the main issues along your chosen pathway or system? 3. What are the root causes which underlie the identified issues?	4. What is likely to happen if we do nothing? 5. Who are the relevant stakeholders (clients, government, service providers, and local government) and what are their underlying motivations? 6. What is the case for change and next steps?
Issues: Early intervention / prevention • Lack of resources and capacity to identify risk indictors • Improve schools and service sector connectivity and access • Refocus funding models towards early intervention and prevention • Establish a Vulnerable Children's Alliance that links universal services (MCH, kindergarten and primary schools) Root causes: • Generational poverty • Lack of inspiration to achieve year 12 or equivalent • High risk indicators for disengagement • Lack of knowledge by young people of flexible learning pathways • Not prepared for employment or education • Lack of apprenticeships places • Siloes schools/education sector	If we do nothing: • no change to rates of year 12 completion or equivalent • young people won't gain meaningful employment • more drain on services and government funding • more welfare funding required of government • schools and education providers will struggle with young people due to limited capacity and resources • wellbeing of young people will fall • general poverty will increase Stakeholders: • Department of Education and Training • DHHS, including Youth Justice and Child Protection • DEEWR / Dept of Innovation XXX • SSSO • SFYS – Peninsula Health and MP Shire • Local government Youth Services • Health and community services Case for change: • Young people disengaging leads to a range of wellbeing issues – mental health, homelessness and AOD Next Steps: • Allocate this work to a Youth Alliance with links to what is happening in YWSAG Project (Care Coordination and e-referral) • Work with the Vulnerable children's and Families Alliance • Get the key stakeholders on board • Find resources

Homelessness	
1. What does your focus area's pathway or system look like and how is the pathway or system performing? 2. What are the main issues along your chosen pathway or system? 3. What are the root causes which underlie the identified issues?	4. What is likely to happen if we do nothing? 5. Who are the relevant stakeholders (clients, government, service providers, and local government) and what are their underlying motivations? 6. What is the case for change and next steps?
Pathway: • Homelessness goes across all areas of the Peninsula Model • Starts at the bottom of the cliff • The pathway does not work at access, service coordination or complex care Issues: • Every access/service should have intake for homeless clients – AOD, health, hospitals • Intolerance – attitudes of Council and community • System is siloed and disconnected – the Stepping Up rep on the group gave an example of a house remaining vacant What is working? • Private rooming house project – 40 residents, coordination of services, client led, partners including landlord, RDNS, Council and now the Mental Health Alliance, shared care and responsibilities; everyone is equal and can swap roles	If we do nothing • Death • Crime • Costs government, hospitals, mental health services Stakeholders: • Two local government areas • Real estate agents • THM services • AOD • Homelessness • Family Violence • Disability • Health • Private rooming house operators Next Steps • Audit systems / housing and homelessness • Seek funding for more housing • Increase the housing stock • Rooming houses and SRS • Gather resources for housing with a focus on houses • Further housing options – MPS land for community housing